AUTHORIZATION ASTHMA, AIRWAY CONSTRICTING OR RESPIRATORY DISTRESS MEDICATION SELF-ADMINISTRATION CONSENT FORM

Student Name (Last/First/Middle)	Birthdate	School	Date

In accordance with applicable laws, students with asthma, airway constricting diseases, respiratory distress or students at risk of anaphylaxis who use epinephrine auto-injectors may self-administer their medication upon the written approval of the student's parents and prescribing licensed health care professional regardless of competency.

In order for a student to self-administer medication, bronchodilator medication via metered dose inhalers (MDI) with or without spacer for asthma or any airway constricting disease:

- Parent/guardian provides signed, dated authorization for student medication self-administration.
- Physician (person licensed under chapter 148, 150, or 150A, physician, physician assistant, advanced registered nurse practitioner, or other person licensed or registered to prescribe or dispense a prescription drug or device in the course of professional practice in Iowa in accordance with section 147.107, or a person licensed by another state in a health field in which, under Iowa law, licensees in this state may legally prescribe drugs) provides written authorization containing:
  - o purpose of the medication,
  - o prescribed dosage, and
  - o times or special circumstances under which the prescribed medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container containing the student's name, name of the medication, directions for use, and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, a may possess and use the student's prescribed medication while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, such as while in before school or after-school care on school-operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school.

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by IOWA CODE § 280.16.

AUTHORIZATION-ASTHMA, AIRWAY CONSTRICTING OR RESPIRATORY
DISTRESS MEDICATION SELF-ADMINISTRATION
CONSENT FORM

Medication	Dosage	Route	Time
_____	_____	_____	_____

_____
Purpose of Medication & Administration /Instructions

_____ _____
Special Circumstances Discontinue/Re-Evaluate/Follow Up Date

_____ _____
Prescriber's Signature Date

_____ _____
Prescriber's Address Emergency Phone

- I request the above-named student possess and self-administer asthma medication via metered dose inhaler (MDI) with or without spacer, or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or interfering with a student's self-administration of medication.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up the remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree to provide the school with back-up medication approved in this form.
- Students will be responsible for maintaining their self-administration record.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Address Home Phone

_____
Business Phone

_____

_____

Self-Administration Authorization Additional Information