Authorization Asthma or Other Airway Constricting Disease Medication or Epinephrine Auto-Injector Self-Administration Consent Form

Student's Name________________________ Birthdate ________ School____________________ Grade________

Medication________________________________ Dosage_____________ Route _____________ Time ____________

Purpose of Medication and Administration Instructions　　　Special Circumstances

Date to Discontinue/Re-evaluate Follow-Up ________

In order for a student to self-administer medication for asthma or any airway constricting disease:

- Parent/Guardian must provide signed, dated authorization for student medication self-administration.
- Physician (a person licensed under chapter 148 to practice medicine and surgery or osteopathic medicine and surgery, an advanced registered nurse practitioner licensed under chapter 152 or 152E and registered with the board of nursing, or a physician assistant licensed to practice under the supervision of a physician as authorized in chapters 147 or 148C) provides written authorization containing: (1) name and purpose of the medication; (2) prescribed dosage; (3) times or special circumstances under which the medication is to be administered.
- The medication must be in the original, labeled container as dispensed or the manufacturer's label containing the student's name, name of medication, directions for use, and date.
- Authorization must be renewed annually. If any changes occur in the medication, dosage, or time of administration, the parent/guardian is to notify school officials immediately.

Provided the above requirements are fulfilled, a student with asthma or other airway constricting disease may possess and use the student's 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

- I request named student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to the authorization and instruction,
- I understand the West Des Moines Community School District and its employees acting reasonably and in good faith shall not be liable 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 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 understand information provided to school personnel will be kept on file in the office of the school nurse.
- I agree to provide the school with back-up medication approved in this form if necessary

Parent/Guardian Information

Signature—I agree to the above statements. ____________________________________ Date________________

Home Address ____ Phone Number________________

Prescriber Information

Signature—I agree to the above statements. ____________________________________ Date________________

Prescriber Address ____ Phone Number________________

Additional Information