



Fairbanks North Star Borough School District

FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
520 Fifth Avenue Fairbanks, AK 99701-4756
(907) 452-2000

MEDICATION ADMINISTRATION: ASTHMA/ANAPHYLAXIS

**Request for Self-Administration of Medication for Asthma or Anaphylaxis
(Inhalers or Auto-Injectable Epinephrine)**

MUST BE COMPLETED ANNUALLY

When this form is completed and signed by the Health Care Provider and returned to the school nurse, the Fairbanks North Star Borough School District may assist parents when their child requires prescribed medication during the school day. The medication **MUST** be in the original pharmacy container labeled with the student's name, dosage, time of administration, prescribing physician, pharmacy, and date.

Student _____ Birthdate _____ Grade _____

Parent/Guardian _____ Phone _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Diagnosis _____

Medication _____ Dosage & Time of Administration _____

- Student may carry inhaler while in school
- Student may carry epinephrine auto-injector while in school

I certify that this student has received instruction in the proper and safe method of self-administration of this medication, that this medication is intended for the sole use of the student and that this student has demonstrated the skill level necessary to use this medication and any device that is necessary to administer the medication as prescribed.

Other Medications Student is Taking _____

Physician _____ Date _____

Physician's Signature _____ Phone _____

PARENT/GUARDIAN ACKNOWLEDGMENT

I, the parent/guardian of the above named student, request that the school district permit the above student to carry and self-administer the medication prescribed by the health care provider. I agree not to institute suit against the school district for administration or non-administration of the medication, to defend and hold the school district harmless from any liability resulting from the administration or non-administration of the medication, and to defend and indemnify the school and its employees from any liability arising out from this agreement. **I will notify the school immediately if the medication is changed and understand that the nurse may contact the health care provider or pharmacist regarding this medication. I understand that when epinephrine is administered either by the school nurse or the student, emergency medical services will be called.**

Parent/Guardian Signature _____ Date _____