Self-Administration for Emergency Medications
Medication Authorization Form
Laramie County School District #2

Child's Name ________________________________ Grade ________ Date ____________

Medication Name ____

Dosage ____________________ Time/Frequency ______________________________

Reason for medication/Diagnosis ____

How is medication taken (circle) oral, inhaled, skin, eyes, ears, other________________________

Possible side effects ____

Special instructions ____

Estimated Termination Date ____
(All authorizations expire at the end of the school year.)

Student is capable of appropriate and accurate self-administration of his/her medication(s), and should be allowed to carry it for this purpose. YES ☐ NO ☐
Medication Location: ____

Physician prescribing____
Physician Signature ____
Physician's address ________________________ Phone number ________________________

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By Signing Below:

1. I am requesting that the medication listed above be taken by my child as directed above. I understand that it is my child's responsibility to report each instance of self-administration to the school nurse or appropriate staff. My child has been instructed in the proper use of the above medication. I certify that my child is capable of self- administration.

2. I acknowledge it is my responsibility to ensure medications are non-expired, in original packaging, and labeled correctly for use.

3. My child and I understand that there are serious consequences for sharing any medications with others. Furthermore, I understand that the school shall incur no liability, and I will hold the school and its employees harmless against any claims relating to self administration of medications. I authorize the release of information between the school and physician pertinent to my child's medication(s).

4. I acknowledge having read and understood W.S. 21-4-310 (provided) and understand the policy of this district regarding self-administration of medication at schools.

5. I understand in the event of an emergency, if my child is unable to self-administer, the School Nurse is not always available to provide care and medication assistance may be provided by trained non-medically licensed school personnel.

Parent/Guardian Name (print) ______________________ Relationship _________________

Parent/Guardian Signature ___________________________ Date _____________________

Wyoming Statute 21-4-310

Self-administration of medication for potentially life threatening conditions

(a) The district board shall permit a student to possess and self-administer within any school of the district medication required for potentially life threatening conditions if a written statement is submitted to the district containing applicable:

(i) Parental verification that the student is responsible for and capable of self-administration and parental authorization for self-administration of medication required for potentially life threatening conditions;

(ii) Health care provider identification of the prescribed or authorized medication required for potentially life threatening conditions and verification of the appropriateness of the student's possession and self administration of the medication required for potentially life threatening conditions.

(b) The written statement shall be prescribed by the department of education, with the assistance of the department of health, and shall require the signatures of the parent or guardian of the student and the student's physician or physician's representative.

(c) As used in this section:

(i) "Asthma medication" means prescription or nonprescription inhaled asthma medication;

(ii) "Potentially life threatening conditions" includes, but is not limited to asthma, food allergies and insect bites;

(iii) "Medication required for potentially life threatening conditions" includes, but is not limited to asthma medication and prescription single dose epinephrine pens.

http://law.justia.com/codes/wyoming/2011/title21/chapter4/section21-4-310