

**Clear Creek Amana Schools**  
**ASTHMA AND/OR AIRWAY CONSTRICTING MEDICATION**  
**SELF-ADMINISTRATION CONSENT FORM**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Student's Name (Last), (First) (Middle)      Birthday      School      Date

In order for a student to self-administer medication (i.e. inhalers, EpiPen<sup>®</sup>,) for asthma and/or any airway constricting disease,

- Parent/guardian provides a signed, dated consent form authorizing self-administration
- A qualified healthcare provider (person licensed under chapter 148, 150, or 150A, physician, physician's assistant, advanced registered nurse practitioner, or other person licensed or registered to distribute 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
  - o times and/or;
  - o special circumstances under which the medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's labeled container containing the student name, name of the medication, directions for use, and date.
- Student practices safe procedures that do not pose a potential harm to others in the school.
- Sharps are properly disposed of in appropriate sharps containers.
- 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 all of the above requirements are fulfilled, a student with asthma and/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-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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

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*.

Medication	Dosage	Route	Time
Medication	Dosage	Route	Time
Medication	Dosage	Route	Time

Purpose of Medication and Administration Instructions \_\_\_\_\_  
 \_\_\_\_\_

Length of Time That This Request Is Effective \_\_\_\_\_

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\_\_\_\_\_  
Special Circumstances

\_\_\_\_\_  
Discontinue/Re-Evaluate/Follow up Date

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Prescriber's Address

\_\_\_\_\_  
Emergency Phone

- I request that the above named student possess and self-administer asthma and/or other airway constricting disease medication(s) at school and in school activities according to this consent form and instructions.
- I understand that 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 remaining medication and equipment.
- I agree that this information may be shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree that any information in this request or any questions that arise from this request may be discussed between school personnel and the prescribing healthcare provider.
- I agree to provide the school with back-up medication approved in this form.
- The student will maintain a self-administration record

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's/Guardian's Address

\_\_\_\_\_  
Cell/Home Phone

\_\_\_\_\_  
Work Phone

Additional Information/Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_