AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION FOR ASTHMA/ALLERGIES K-12 AND INSULIN FOR GRADES 6-12

PIPER USD 203

Part A

Parent to Complete

Name of Student: _____ Date of Birth: _____ Grade/Teacher: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the selfadministration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I also acknowledge, in accordance with the Nurse Practice Act, the need and give permission for appropriate communication between the school nurse and the medical prescriber related to the medication(s)/treatment(s) in question to enable the nurse to administer safe and effective care. This includes communication concerning the prescription/treatment itself, implementation of the prescription/treatment in school, student response to the medication/treatment, and other pertinent issues related to the student's diagnosis, condition, or medication/ treatment.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Printed Name	Today's date

Part B

Physician to Complete

Current Diagnosis(es): _____ _____ _____

Medication / Treatment	Dosage	Time / Frequency	Duration

Special Instructions: _____

_____	_____	_____	_____
Provider Signature	Provider Printed Name	Office Phone Number	Today's Date

Part C

School Nurse to Complete

School Nurse Review of order and procedure with student. Completed satisfactorily: _____
Date of review

Written authorization to self-administer prescription drugs will expire automatically at the end of each school year. A new authorization will be required annually and dated after May 1 of the preceding school year.