

AUTHORIZATION-ASTHMA OR AIRWAY CONSTRICTING MEDICATION
SELF-ADMINISTRATION CONSENT FORM

Medication	Dosage	Route	Time
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Purpose of Medication & Administration /Instructions

Special Circumstances	_____/_____/_____ Discontinue/Re-Evaluate/ Follow-up Date
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Prescriber's Signature	_____/_____/_____ Date
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Prescriber's Address	Emergency Phone
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- I request the above-named student possess and self-administer asthma, medication, bronchodilator canisters or spacers or other airway constricting disease medication(s) **and/or an epinephrine delivery system** at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication **or an epinephrine delivery system** or for supervising, monitoring, or interfering with a student's self-administration of medication **or an epinephrine delivery system. I acknowledge that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication or use of an epinephrine delivery system by the student.**
- 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 agree to provide the school with back-up medication approved in this form.
- Student maintains self-administration record.

Parent/Guardian Signature (agreed to above statement)	_____/_____/_____ Date
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Parent/Guardian Address	Home Phone
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Business Phone

Self-Administration Authorization Additional Information