AUTHORIZATION ASTHMA, AIRWAY CONSTRICTING, ***OR RESPIRATORY DISTRESS*** MEDICATION SELF-ADMINISTRATION CONSENT FORM

_____ ___/___/___ _____ ___/___/___
Student's Name (Last), (First) (Middle) Birthday School Date

In order for a student to self-administer medication for asthma ***medication, bronchodilator canisters or spacers*** or any airway constricting disease ***medication or for a student with a risk of anaphylaxis to self-administer an epinephrine auto-injector***:

- Parent/guardian provides signed, dated authorization for student medication self-administration.
- ~~Physician~~ ***Parent/guardian provides signed, dated authorization from the student's licensed health care professional*** (person licensed under chapter 148 ***to practice medicine and surgry or osteopathic medicine and surgery, an advanced registered nurse practitioner licensed under chapter 152 or 152E and registered with the board of nursing, or a physician assistant licensed to practice under the supervision of a physician as authorized in chapters 147 and 148C*** ~~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 ***the following***:
    - ***Name and*** purpose of the medication,
    - prescribed dosage,
    - times or special circumstances under which the medication ***or epinephrine auto-injector*** 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.
- Authorization is renewed annually. ***In addition,*** 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 the above requirements are fulfilled, a student with asthma, ***respiratory distress*** 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-school 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

_____
Purpose of Medication & Administration /Instructions

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

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|---|---|
| Special Circumstances | / / Discontinue/Re-Evaluate/ Follow-up Date |
| Prescriber's Signature | / / Date |
| Prescriber's Address | Emergency Phone |

- I request the above named student possess and self-administer asthma, ***medication, bronchodilator canisters or spacers*** or other airway constricting disease medication(s) 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 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 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.

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

Self-Administration Authorization Additional Information