



**AUTHORIZATION FOR
ADMINISTRATION OF ASTHMA OR
OTHER AIRWAY CONSTRICTING
DISEASE MEDICATION**

NOTE: For Staff administration and supervision, Sections I and II must be completed. **Student Self-Administration including the carrying of medication on their person shall only be allowed if Sections I and III below are completed.**

Student _____ Birthdate ____/____/____
 (First) (Last) Mo. Day Yr.
 School _____ School Year _____

Medications/Inhalers/Nebulizers, which cannot be managed at home, shall be administered at school when the following are on file at the school:

- Authorized health care provider’s signed and dated authorization which includes the: name and purpose of the medication, diagnosis of asthma or other airway constricting diseases, procedure, dosage, route, time to be given at school, dosage repeat, symptoms, and side effects.
- Parent/Guardian signed and dated authorization.
- Medication/equipment in the original packaging.
- A prescription label attached to the inhaler and / or inhaler carton and / or medication container.
- Authorization orders that match the prescription label on the medication container(s).
- Annual renewal of authorization/permission and immediate notification, in writing, of changes.

I. MEDICAL PROVIDER AUTHORIZATION SECTION (To be filled out by medical provider with authority to prescribe)

The above named student is under my medical supervision. I have prescribed the following:

Name of Inhaler/Nebulizer/ Medication	Dosage	Route

Purpose of Medication	Diagnosis/ICD9 Code

Time or special circumstances when medication is to be given at school _____

How soon can dosage be repeated? _____

Anticipated reactions/possible side effects _____

Medical Provider Signature _____

Date _____ Phone _____ Fax _____

II. PARENT AUTHORIZATION FOR ADMINISTRATION

I request the above student be administered the medication in accordance with the health care provider certification above while in school and school related activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication/procedure where the person administering the medication/procedure acts as a reasonably prudent person would under the same or similar circumstances.

Qualified staff will do administration and the medication/inhaler/nebulizer will be kept in a secured location.

Parent Signature _____ Date _____

Section III on back

III. PARENT AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION

NOTIFICATION TO PARENT: The school district 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 school district and its employees shall incur no liability for any improper use of the medication, or for supervising, monitoring, or interfering with a student's self-administration of medication if acting reasonably and in good faith. As the school will not require proof of competency, the parent/guardian must take responsibility for ensuring that the student has been properly instructed on self-administration.

PERMISSION FOR STUDENT SELF-ADMINISTRATION AND ACKNOWLEDGMENT

I request that my student be allowed to possess and self-administer the student's medication in accordance with the health care provider certification above while at school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities. I understand that if my student misuses this privilege, the privilege may be withdrawn.

I acknowledge that the school district 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 my student. The school district and its employees shall incur no liability for any improper use of the medication, or for supervising, monitoring, or interfering with my student's self-administration of medication if acting reasonably and in good faith.

I understand that my student must maintain his or her own self-administration record when carrying the medication on his/her person.

I acknowledge that this Authorization must be renewed annually and that I must immediately inform the school in writing of any changes to the information contained in this authorization.

Parent/Guardian Signature _____ Date _____

It is the policy of the Sioux City Community School District to not discriminate on the basis of race, color, creed, religion, sex, age, disability or marital status in its educational programs, activities and employment practices. Inquiries or grievances regarding compliance with Title II, Title IV, Title VII, Title IX and Section 504 of the Rehabilitation Act of 1973 may be directed to the director of educational equity, Ms. Marilyn Charging, Educational Equity Office, Education Service Center, Sioux City Community Schools, 1221 Pierce Street, Sioux City, IA 51105-1497, (712) 279-6075.