AUTHORIZATION FOR ADMINISTRATION OF ASTHMA OR OTHER AIRWAY CONSTRICTING DISEASE MEDICATION

Board Policy 504.12-E(i)

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/ICD-10 Code** (Must have for Medicaid)

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 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 Educational Rights & Privacy Act (FERPA) and any other applicable laws.

I agree to provide the school with back-up medication approved in this form.

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_____