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

In order for a student to self-administer medication for asthma or any airway constricting disease:

- Parent/guardian must provide a signed, dated authorization for student medication self-administration.
- Physician (person licensed under chapter 148, 150, or 150A), 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), must provide written authorization containing:
  - Purpose of the medication,
  - Prescribed dosage,
  - Times or;
  - Special circumstances under which the medication is to be administered.
  - Student's known diagnosis and ICD 10 codes
- The medication must be in the original, labeled container as dispensed or the manufacture's labeled container containing the student's name, name of the medication, directions for use, and date.
- Authorization must be renewed annually. 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 or other airway constricting disease may possess and use the student's medication while in school, at school-sponsored activities, and before and after normal school activities, such as while in before-school or after-school care on school 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.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 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 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.

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I am the parent/guardian/custodian of ______________________________ (student's full legal name), date of birth ______________________________in the ___________ Building in the Burlington Community School District.

Medication	Dosage	Route	Time

Purpose of Medication & Administration Instructions

Special Circumstances

Discontinue or Re-Evaluate Date (mark which)

Medical Provider's Information

Student's Diagnosis and ICD 10 codes: ______________________________

Prescriber's Signature

Date

Prescriber's Printed Name

Prescriber's Address

Emergency Phone

Parent Statement:

- I request the above named student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions. Medications are solely for the use of the prescribed student. Sharing of medication is not allowed.
- I understand the Burlington Community 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 timely provide safe delivery of medication and equipment to and from school and to timely pick up remaining medication and equipment.
- I agree to provide the school with back-up medication approved in this form.

Parent/Guardian Signature (agree to above statement)

Date

Parent/Guardian Address

Email Address

Home/Cell Phone

Approved: 04/10/07 Reviewed: ~~07/18/16~~ 11/15/21

Self-Administration Authorization Additional Information (if needed)

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