

AUTHORIZATION-ASTHMA, AIRWAY CONSTRICTING, OR RESPIRATORY DISTRESS
MEDICATIONSELF-ADMINISTRATION CONSENT FORM

Medication Dosage Route Time

Purpose of Medication & Administration /Instructions

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, bronchodilators canisters or spacers, or other airway constricting disease medication(s) and/or an epinephrine auto-injector 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 auto-injector or for supervising, monitoring, or interfering with a student's self-administration of medication or use of an epinephrine auto-injector. 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 auto-injector 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) and any other applicable laws.
- 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

Parent/Guardian Address Home Phone

Business Phone

Self-Administration Authorization Additional Information