Self-Administration Authorization at John F. Kennedy Catholic School: Asthma or Airway Constricting Medication

_____ _____ _____

Student's Name (Last) (First) (Middle) Birthday Date

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

- Parent/guardian provides a signed, dated authorization for student self-administration.
- Physician (person licensed under chapter 148, 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, licenses in this state may legally prescribe drugs) provides written authorization containing purpose of the medication, prescribed dosage, times or special circumstances under which the medication 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. If any changes occur in the medication, dosage or time of administration, the parent is to immediately notify school officials and 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, 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

The school and its employees are to incur to liability, except for gross negligence, as a result of any injuring arising from self-administration of medication by the student. The parent/guardian of the student shall sign a statement acknowledging that the 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/Health Care Dosage Route Time at School

Purpose of Medication/Administration Instructions:_____

_____

Special Circumstances:_____

_____

Discontinue/Re-evaluate/Follow-up Date:_____

(Over) (Over) (Over)

To be completed by a prescriber:

Prescriber	Date
Prescriber's Address	Prescriber's Emergency Phone

- I request the above 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.
- I understand the school 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 prescriber 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.

Parent/Guardian Signature	Date
Parent/Guardian Address	Home Phone
Additional Information	Work Phone/Other Phone