DES MOINES PUBLIC SCHOOL DISTRICT

Asthma or Airway Constricting Medication Self-Administration

Physician Authorization Form

_____	___/___/___	___/___/___
Student's Name (Last), (First) (Middle)	Birthdate	Date

I recommend that the above named student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to this authorization and instructions.

_____	_____	_____	_____
Medication	Dosage	Route	Time

_____

Purpose of Medication & Administration Instructions

_____

Special Circumstances

_____	_____/ /
Prescriber's Signature	Date
_____	_____
Prescriber's Address	Emergency Phone

Note: To be updated annually

Asthma or Airway Constricting Medication Self-Administration
Parent Consent Form

_____ ___/___/___ ___/___/___

Student's Name (Last), (First) (Middle) Birthdate Date

I request that my child named above be allowed to possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to this consent.

- I understand that my student's physician must provide written authorization containing the name and purpose of the medication, the prescribed dosage, and the times or special circumstances under which the medication is to be administered.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- 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 for supervising, monitoring, or interfering with a student's self-administration of medication.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I permit information about my child's medication needs to be 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, as needed, in the original, labeled container as dispensed containing the student name, name of the medication, directions for use, and date.
- I authorize the school nurse to contact my child's physician to clarify orders related to the use of the medication.
- I understand that this authorization will need to be renewed every year.

Physician's Name _____ Telephone number _____

I have consulted with my child and we have agreed that the medication will be maintained in a consistent place during the school day. This place is identified as:

_____

(Write in place where medication will be kept.)

_____ _____/_____/_____

Parent/Guardian Signature Date
Agreed to Above Statement