West Des Moines Community School District
Authorization For Asthma or Airway Constricting Medication Self-Administration
Consent Form

_____ ___/___/____ _____ ___/___/___
Student's Name **Birthday** **School** **Date**

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

- Parent/Guardian provides signed, dated authorization for student medication self-administration.
- Physician (person licensed under chapter 148, 150, or 150A or section 147.107) provides written authorization containing: (1) purpose of the medication; (2) prescribed dosage; (3) times; (4) special circumstances under which the medication is to be administered.
- The medication is in the original, labeled container as dispensed or the manufacturer's label containing the student's name, name of medication, directions for use, and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage, or time of administration, the parent/guardian is to notify school officials immediately.

Provided the above requirements are fulfilled, as 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.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 parent/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 by the student as established by Iowa Code
ξ 280.16

- I request 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.
- I understand the West Des Moines 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 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 if necessary.

Medication_____ **Dosage**_____ **Route**_____ **Time**_____

Purpose of Medication and Administration Instruction:_____

Special Circumstances_____ **Date to Discontinue/Re-evaluate/Follow-up**_____

Parent/Guardian Signature (I agree to the above statements)_____ **Date**_____

Parent/Guardian Home Address_____**Home Phone**_____

Prescriber's Signature_____ **Date**_____

Prescriber's Address_____ **Phone #**_____

Additional Information:_____

_____

Original = School Copy **Pink = Parent Copy** **Yellow = Provider copy**

Originated 8/04