Authorization - Asthma or Airway Constricting Medication
Self-Administration Consent Form

Student/Participant's Name (Last) (First) (M.I.)	**Birthdate**	**Name of School/Parish**	**Today's Date**

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

- Parent/guardian provides signed, dated authorization for student self-administration.
- Physician (person licensed under Iowa 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, licensees 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/participant's 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/guardian is to notify school/program officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, a student/participant with asthma or other airway constricting disease may possess and use the student/participant's medication while in school/program, at school/program sponsored activities, under the supervision of school/program personnel, and before or after normal school/program activities. If the student/participant abuses the self-administration policy, the ability to self-administer may be withdrawn by the school/program administrator or discipline may be imposed.

Medication	Dosage	Route	Time

Purpose of Medication & Administration/Instructions

Please Complete Both Pages of Form

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Special Circumstances	Discontinue/Re-Evaluate/Follow-up Date
Prescriber's Signature	____/____/____ Date
Prescriber's Address	Emergency Phone

- I request the above student/participant possess and self-administer asthma or other airway constricting disease medication(s) at school/program and in school/program activities according to the authorization and instructions.
- I understand the school/program 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/participant's self-administration of medication.
- I agree to coordinate and work with school/program 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/program and to pick up remaining medication and equipment.
- I agree the information is shared with school/program personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree to provide the school/program with back-up medication approved in this form.
- Student/participant maintains self-administration record.

Parent/Guardian Signature	____/____/____ Date
Parent/Guardian Address	Home Phone
	Daytime Phone

Self-Administration Authorization Additional Information

Please Complete Both Pages of Form