AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL
REMSEN-UNION COMMUNITY SCHOOLS

Student Name: _________________________ Date of Birth: ___/___/_____ Today's Date: ____________

School medications and health services are administered following these guidelines:

- • Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- • The medication is in the original, labeled container as dispensed or the manufacturer's labeled container. *Please request an extra, labeled container from your pharmacy for this purpose.*
- • The medication label contains the student's name, name of the medication, directions for use, and date.
- • The parent will notify the school immediately when changes occur in medication, dosage or time of administration.

Medication/Health Service: ____

Dosage: _______________________________ **Route:** __________________________

To be given at the following time(s): ____

Special Instructions and Possible Side Effects: ____
____
____
____

Prescriber's Name: __________________________ **Date:** ___________

Discontinue/Re-Evaluate/Follow-up Date: ________________________

Prescriber's Address: ____

Emergency Phone: __________________________

I request the above student receive medication/health service at school and school activities, according to the prescription, instructions, and a written record kept. Special considerations are noted above. The information is confidential except as provided to the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with school personnel and prescriber when questions arise. I agree to provide safe delivery of medication and equipment to and from school and to pick p remaining medication and equipment.

Parent's Signature: ___________________________________ **Date:** _________________

Parent's Address: _____________________________________ **Home Phone:** ____________________

_____________________________________ **Business Phone:** ___________________

Cell Phone: _______________________

Additional Information: ____
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AUTHORIZATION-ASTHMA OR AIRWAY CONSTRICTING MEDICATION SELF-ADMINISTRATION CONSENT FORM
REMSEN-UNION COMMUNITY SCHOOLS

Student Name: _________________________ Date of Birth: ___/___/_____ Today's 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, 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:
    - o purpose of the medication,
    - o prescribed dosage,
    - o times, or;
    - o 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.
- • If any changes occur in the medication, dosage or time of administration, the parent is to notify the school officials immediately.

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.

Pursuant to state law, the school district or accredited nonpublic school and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or 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 of medication by the student as established by *Iowa Code* § 280.16.

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 or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonable 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 nd 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.
- Student maintains self-administration record.

Parent/Guardian Signature: ________________________________ **Date:** ______________

Parent/Guardian Address: _________________________________ **Home Phone:** ________________

_________________________________ **Business Phone:** _____________

Cell Phone: __________________

Self-Administration Authorization Additional Information: ____
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