

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

Medication	Dosage	Route	Time
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 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) and/or an epinephrine auto-injector at school and in school activities according to the authorization and instructions.
- 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 an epinephrine auto-injector or for supervising, monitoring, or interfering with a student's self-administration of medication or use of an epinephrine auto-injector. I acknowledge that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication or use of an epinephrine auto-injector by the student.
- 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) and any other applicable laws.
- I agree to provide the school with back-up medication approved in this form.

 Parent/Guardian Signature (**agreed to above statement**)

 Date

 Parent/Guardian Address

 Home Phone

 Business Phone

 Self-Administration Authorization Additional Information
