

Student Personnel

Series 500

Policy Title Parental Authorization and Release Form for the
Administration of Asthma Medication to Student

Code No.506.4E2

Starmont Community School District
AUTHORIZATION FORM
Self-Administration of Asthma or Airway Constricting Medication

Student's Name (Last) (First) (Middle) Birth date

The 2004 General Assembly of the state of Iowa enacted a new law, signed by the governor, which allows students with asthma or other airway constricting diseases (such as emphysema) to self-administer medication at school with signed parental and physician consent. Under the new law the student does not have to show "competency" in order to be allowed to self-administer. The school district merely needs to have the parental and physician consent form on file.

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

- The parent/ guardian must provide signed, dated authorization
- A physician or other person licensed to dispense prescription medication in Iowa must provide written authorization containing:
 - Purpose of the medication
 - Prescribed dosage
 - Times or the special circumstances under which the medication is to be administered
- The medication is in the original, labeled container as dispensed and includes the student 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, it is the parent/guardian's responsibility to notify the school nurse immediately.

Provided the above requirements are fulfilled, a student with asthma or other airway constricting disease may possess and use their 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.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 Starmont School District 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 this student. The parent or guardians signature on this form acknowledges their acceptance of all of the information on this page including this paragraph.

Parent/Guardian Consent

I have read all of the above information and consent to these rules:

Parents or Guardians Signature

Date signed

Student Personnel

Series 500

Policy Title Parental Authorization and Release Form for the Administration of Medication to Student Code No. 506.4E1

The undersigned(s) are the parent(s), guardian(s), or person(s) in charge of _____ (student's full legal name), who is in the _____ grade at the _____ building in the Starmont Community School District.

It is necessary that the above student receive the following medication(s), at the following frequencies, for the following time period (*Attach additional sheets if necessary*):

(a) _____
(Medication)

(Frequency (*i.e., once at noon, etc.*))

Beginning on _____ and continuing through _____.
(Duration)

_____ I hereby request the Starmont Community School District, or its authorized representative, to administer the above-named medication to my child named above and agree to:

1. Submit this request to the principal or school nurse;
2. Personally ensure that the medication is received by the principal or school nurse administering it in the container in which it was dispensed by the prescribing physician or licensed pharmacist or is in the manufacturer's container;
3. Personally ensure that the container in which the medication is dispensed is marked with the medication name, dosage, interval dosage, and date after which no administration should be given. OR

_____ I hereby authorize my child to self-administer his/her medication as he/she has shown the competency to do so. I hereby agree to:

1. Submit this request to the principal or school nurse;
2. Personally ensure that
 - a. the medication is received by the principal or school nurse administering it in the container in which it was dispensed by the prescribing physician or licensed pharmacist or is in the manufacturer's container; or
 - b. the medication will be kept in the student's possession but only with prior written permission from the parent and principal.
3. Personally ensure that the container in which the medication is dispensed is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.

(Signature of Parent/Guardian)

(Date)

(Printed Name of Parent/Guardian)

(Phone Number)

Physician's Authorization

Starmont Student's Name

May possess and use their medication for asthma or other airway constricting disease 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.

Medication: _____

Dosage: _____

Route: _____

Special Circumstances: _____

Prescriber's Signature: _____ Phone: _____

Prescriber's Address: _____ Date: _____

Parent/Guardian Consent

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 listed above by their prescription prescriber.

I agree that Starmont and its employees acting reasonably and in good faith shall incur no liability for any improper use of this medication or for not supervising or monitoring, this student's self administration of this medication.

I agree to notify the school nurse when conditions or prescriptions change.

I acknowledge that the information on these 2 pages will be shared with school personnel in accordance with the Family Education Rights and Privacy Act.

Date

Parent/Guardian Signature

Phone numbers