

# Authorization and Permission for Administration of Medication

\_\_\_\_\_  
Student's Name (Last)      (First)      MI      Birthday      School      Date

School medications and health care services are administered following these guidelines:

Parent signed, dated authorization to administer the medication.

The medication is in the original labeled container as dispensed or the manufacturer's labeled container.

The medication label contains the student name, name of medication, directions for use and date.

Annual renewal of authorization and immediate notification, in writing, of changes.

\_\_\_\_\_  
Medication/Health Care      Dosage      Route      Time at School

\_\_\_\_\_  
Administration instructions

\_\_\_\_\_  
Discontinue/Re-Evaluate/Follow-up Date

\_\_\_\_\_  
Prescriber

\_\_\_\_\_  
Date

\_\_\_\_\_  
Prescriber's Address

\_\_\_\_\_  
Emergency Phone

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Additional Information

\_\_\_\_\_  
Business Phone

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student's Name (Last), (First) (Middle) \_\_\_\_\_ / / \_\_\_\_\_ 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.
- Physicians (person licensed under chapter 148, 150, or 150A, 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 on 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.
- Authorization is renewed annually. If any changes occur in the medication, dosage, or time of administration, the parent is to notify 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 or nonpublic school 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 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.
- (Student maintains self-administration record.) (Note: *This bullet is recommended but not required.*)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
(agree to above statement)