AUTHORIZATION FOR STUDENT ASTHMA MEDICATION SELF-ADMINISTRATION
(Established by Iowa Code 280.16)

Student Name	Birthdate	Date
_____	_____	_____

Medication	Dosage	Route	Time
_____	_____	_____	_____

Purpose of medication and administration special instructions:

_____

_____

- ✓ The medication must be in the original, labeled container including the student's name, direction's for use, health care provider's name and date.
- ✓ This authorization must be renewed annually.

Prescriber's Signature **Date**

_____ _____

I request the above named students 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.
- If Cedar Rapids Community School District personnel determine a student abuses the self-administration, the appropriate personnel may either withdraw the self-administration privilege, if medically advisable, or discipline the student, or both
- 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 can be 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.

_____ _____

Parent/Guardian Signature (agree to above statement) Date

11/04