

MOC-FLOYD VALLEY COMMUNITY SCHOOL DISTRICT

Student Health and Safety Regulations

504

POLICY TITLE: Authorization-Asthma or Airway Constricting Medication
Self-Administration Consent Form CODE NO.
504.14R

_____/_____/_____ ____/____/_____ _____
_____/____/_____ Birthday School
Date Student's Name

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, licenses in this state may legally prescribe drugs) provides written authorization containing:
 - Purpose of the medication,
 - Prescribed dosage
 - Times, or;
 - 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.
- Authorization is renewed annually. If any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

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, 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 If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.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
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Purpose of Medication & Administration/Instructions

Special Circumstances evaluate/	Discontinue/Re- Follow-up Date
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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 or 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.

Parent/Guardian Signature
(agreed to above statement)

Date

Parent/Guardian Address

Home Phone

Work Phone