4/2007

HARLAN COMMUNITY SCHOOLS
AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

STUDENT NAME: _____

DATE: _____ DOB: _____ GRADE: _____

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

- Parents 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 the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing, of changes.
- A physician must sign this form for any prescription to be administered at school.
- A physician's signature is required if an over-the-counter medication is to be taken more than five consecutive days.

Medication: _____

Dosage: _____ Time to be give at school: _____

Prescribing Physician's Name (printed): _____

Prescribing Physician's **Signature**: _____
(Required for prescription medications and over the counter medications administered for more than five consecutive days)

I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or no-prescription instructions and a record be 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 reasonably prudent person would under the same or similar circumstances. I hereby release the school from any claims of negligence for the administration or for failing to administer this medication to my child. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

Parent Signature: _____

Date: _____ Daytime Phone: _____

Date Given	Signature of staff member

A COPY OF THE MEDICATION POLIDY CAN BE FOUND IN THE STUDENT HANDBOOK.
MEDICATIONS THAT ARE PRESCRIBED TO BE GIVEN THREE TIMES DAILY CAN BE GIVE AT HOME UNLESS TIMES HAVE BEEN

Harlan Community Schools
Asthma/Airway Constricting Medication Self-Administration

Student Name: _____ DOB: _____ Grade _____

In order for a student to self-administer asthma or medication for an 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, Iowa law, licensees 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's 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 immediately notify school officials and the authorization shall be reviewed as soon as practical.

Provide the above requirements are fulfilled, a student with asthma or other airway constriction 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.

The 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 the student. The parent/guardian of the student shall sign a statement acknowledging that the school district is to incur no liability, except for gross negligence, as a result of the self-administration of medication by the student as established by Iowa Code 280.16

Medication: _____ Dosage: _____

Route: _____ Time: _____

Purpose of Medication/Administration Instructions: _____

_____

Prescriber Name: _____ Prescribers Phone # and Fax # _____

Prescribers Signature: _____ Date: _____

- I request the above 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 prescribe when questions arise to 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 the form.
- (Student maintains self-administration record.)

Parent/Guardian Signature (agree to above): _____ Date: _____

Home Phone: _____ Business/Cell Phone: _____

Self-Administration Authorization Additional Information: _____

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