Dear Parents:

In Iowa there is a law which states students with asthma or other airway constricting diseases are allowed to self-administer their medication (inhalers) at school.

If you would like your child to be allowed to carry and to self-administer medication for asthma or any airway constricting disease:

- The parent/guardian provides a signed, dated authorization for student medication self-administration.
- The doctor prescribing the asthma or airway constricting medication provides a written authorization containing:
    1. Name of the medication
    2. Purpose of the medication
    3. Prescribed dosage
    4. Times or special circumstances under which the medication is to be administered
- The medication must be in the original, labeled container as dispensed. (The prescription must be on the container.)
- This form must be signed annually, and if there is any change to the prescription, it is the parents' 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 If the student abuses the self- administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.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 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.

Please complete the form on the reverse side and return to the school nurse. Please note that the form needs to be signed by the parent/guardian and also the physician prescribing the asthma or other airway constricting medication.

If you would like any asthma or other airway constricting medicine be kept in the nurse’s office and the nurse to assist your child in the use of their medicine such as an inhaler, no physician signature is required. Please complete the form and return with the medication to the school nurse.
Thank you.

South Hardin Schools
Nurse Amy, School Nurse

Asthma or Airway Constricting Medication Consent Form

Student's Name: _____ Date of Birth _____
Medication: _____
Purpose for medication: _____
Dosage: _____
Times for Administration: _____
Additional Information or Administration Instructions: _____

Mark the appropriate option and complete the form as required:

___ My child will not require medication at school at this time.
(Complete student's name, date of birth, sign consent and return to school nurse).

___ My child's asthma or airway constricting medication is to be kept in the nurse's office.
(Complete student's name, date of birth, sign consent and return to school nurse).

___ My child will be allowed to carry and self-administer asthma or other airway constricting disease medication at school and in school activities according to the authorization and instructions. *(Complete student's name, date of birth, sign consent, obtain physician signature and return to school nurse).*

- ❑ **I understand the school district and its employees acting reasonable 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 at the end of the year**
- ❑ **I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act.**

Parent/Guardian Signature: _____Date: _____

Physician Signature: _____Date: _____
*(Required **only** if student will be carrying and self-administering asthma or air constricting medicine)*