			way Constricting Me ion Consent Form	edication	
		/ /		/ /	
Student's Name (Last)	, (First) (Middle)	Birthday	School	Date	
In order for a student	to self-administer n	nedication for ast	hma or any airway c	onstricting disease:	
Physician (per registered nur drug or device person licens	erson licensed und rse practitioner, or ce in the course o	er chapter 148, other person lice of professional profess	150, or 150A, physical consections or registered to ractice in Iowa in action which, under I	eation self-administration, physician's assistant distribute or dispense cordance with section owa law, licensees in	stant, advanced e a prescription n 147.107, or a
presc.times	•		edication is to be adn	ninistered.	
containing the Authorization	e student name, name is renewed ann n, the parent is to r	ne of the medicat ually. If any	ion, directions for us changes occur in	the manufacturer's la e, and date. the medication, dosa he authorization shall	ige or time of
school personnel, and	student's medication before or after nor erty. If the student	n while in schoo mal school activi abuses the self-a	l, at school-sponsore ties, such as while in	ther airway constriction and activities, under the before-school or after the ability to self- adm	e supervision of r-school care on
except for gross negli The parent or guardia	gence, as a result on of the student so liability, except for	of any injury aris shall sign a state or gross negligen	sing from self-admin ment acknowledging	ts employees are to in istration of medication that the school distri E-administration of me	by the student.
Medication	Dosage	Route		Time	

Purpose of Medication & Administration /Instructions

Authorization-Asthma or Airway Constricting Medication Self-Administration Consent Form

Special Circumstances	Discontinue/Re-Evaluate/
Special Chedinstances	Follow-up Date
Prescriber's Signature	Date
Prescriber's Address	Emergency Phone
 medication(s) at school and in school activities at I understand the school district and its employee for any improper use of medication or for self-administration of medication I agree to coordinate and work with school perconditions change. I agree to provide safe delivery of medication at medication and equipment. 	s acting reasonably and in good faith shall incur no liability supervising, monitoring, or interfering with a student's rsonnel and notify them when questions arise or relevant and equipment to and from school and to pick up remaining sonnel in accordance with the Family Education Rights and
Parent/Guardian Signature (agreed to above statement)	Date
Parent/Guardian Address	Home Phone
	Business Phone