PROCEDURES EXHIBIT: 503.7B

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

Special Circumstances _____

Discontinue/Re-Evaluate/Follow-up Date _____

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 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.
- 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 _____ Date _____

Parent/Guardian Address _____ Home Phone _____

Business Phone _____

Self-Administered Authorization Additional Information _____

Revised
Reviewed 07/06/09. 02/23/15, 09/23/19