Authorization-Asthma or Airway Constricting Medication Self-Administration

Howard-Winneshiek Community School District
fax 1-563-547-2079

Consent Form

Student's Name (Last), (First) (Middle) _____ Birthday __/__/__ School _____ Date __/__/__

Medication _____ Dosage _____ Route _____ Time _____

Purpose of Medication & Administration /Instructions _____

Special Circumstances _____ Discontinue/Re-Evaluate/ Follow-up Date __/__/__

Physician's Signature _____ Date __/__/__

Physician'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.
- I authorize school personnel to share pertinent information and contact my child's doctor, if necessary.
- Student maintains self-administration record.

Parent/Guardian Signature (agreed to above statement) _____ Date __/__/__

Parent/Guardian Address _____ Home Phone _____

Business Phone _____