LEARNER SELF-ADMINISTRATION OF ASTHMA OR ANAPHYLAXIS MEDICATION AUTHORIZATION FORM
PHYSICIAN/LICENSED HEALTH CARE PROVIDER STATEMENT

The learner ____ has

______ asthma

______ anaphylaxis

______ both asthma and anaphylaxis and is capable of self-administering the following medication:

Name and purpose of medication: ____

____

Prescribed dosage of medication: ____

____

Times at which or circumstances under which the medication may be administered: _____________________

____

Period for which the medication is prescribed: ____

____

____ ____________________

Signature of Physician/Other Licensed Health Care Provider Date

PARENTAL AUTHORIZATION

1. I am the parent/guardian of ____ and I authorize my child/ward ____ to self-administer the prescription medication identified above while on school property or at a school-related event or activity.

2. I hereby release the District and its employees and agents from liability for injury arising from the learner's self-administration of the prescription medication while on school property or at a school-related event unless in cases of wanton or willful misconduct.

3. I understand that if the learner identified above herein uses the medication in a manner other than prescribed, the learner may be subject to disciplinary action by the school, however, any disciplinary action may not limit or restrict the learner's immediate access to the medication.
4. I authorize the school nurse to inform appropriate school employees (i.e., instructors, teacher aides, school administrators, activity supervisors, bus drivers who would have a need to know) that the learner may self-administer medication.

5. I give permission for the learner to have the prescription medication with the learner while on school property or at a school-related activity or event.

____ ____________________

Signature of Parent/Guardian Date

Notification: **05/09/2022**
1st Reading: **06/21/2022**
2nd Reading/Adopted: **09/12/2022**