VALLEY CITY PUBLIC SCHOOL DISTRICT #2 VALLEY CITY, NORTH DAKOTA 58072 EMERGENCY MEDICATION CHECK-IN FORM	Descriptor Code ACBD-E4	1st Reading 8/9/18
	Adopted 8/9/18	Revised/Rescinded

EMERGENCY MEDICATION CHECK-IN FORM

NOTE: To be completed by an eligible school medication provider prior to authorizing a student to self-administer emergency medication under NDCC 15.1-19-16.

Student's name: _____
Date of birth: _____
Grade level: _____
Today's date: _____

Definition of Emergency Medication
Emergency medication includes a prescription drug delivered by inhalation to alleviate asthmatic symptoms and an epinephrine auto-injectable pen.

Authorization Requirements
A student who has been diagnosed with asthma or anaphylaxis may possess and self-administer emergency medication for the treatment of such conditions provided the student's parent/guardian files with the school a document that meets all of the following requirements:

- Indicates that the student has been instructed in the self-administration of emergency medication for the treatment of asthma or anaphylaxis.
  Documentation received by school: ☐ Yes ☐ No

- Lists the name, dosage, and frequency of all medication prescribed to the student for use in the treatment of the student's asthma or anaphylaxis.
  Documentation received by school: ☐ Yes ☐ No

- Includes guidelines for the treatment of the student in the case of an asthmatic episode or anaphylaxis.
  Documentation received by school: ☐ Yes ☐ No

To be completed by the student's parent/guardian:
I understand the school, school district, and any employee or volunteer of the District is not liable for civil damages incurred by:

a. A student who administers emergency medication to himself or herself.
b. An individual because a student was permitted to possess emergency medication.

Parent/guardian's name (Printed)

Parent/guardian's signature Date

To be completed by an authorized school medication provider:
I certify that the student's parent/guardian has submitted all documentation required for the student to self-administer emergency medication.

Name of school medication provider (Printed)

Signature of School Medication Provider Date