AGWSR Community School District

ASTHMA/OTHER AIRWAY CONSTRICTION DISEASE MEDICATION OR EPINEPHRINE AUTO-INJECTOR SELF-ADMINISTRATION CONSENT

_____	___/___/____	_____	___/___/____
Student's Name	Birthday	School Campus	Date

- I request the above named student possess and self-administer asthma or other airway constricting disease medication(s) and/or an epinephrine auto-injector 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 an epinephrine auto-injector for supervising, monitoring, or interfering with a student's self-administration of medication or use of an epinephrine auto-injector. I acknowledge that the school district is to incur no liability, except for gross negligence, as a result of self-administration or use of an epinephrine auto-injector by the student.
- 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. The medication must be in the original, labeled container and medication label contains the student's name, name of medication, directions for use, and date.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA) and any other applicable laws.
- I agree to provide the school with back-up medication approved in this form.
- **As the prescribing provider, I agree that the above named student is competent to self-administer below medications(s).

_____	_____	_____	_____
Medication	Dose	Route	Time/Frequency

_____	___/___/____
Purpose of medication & administration instructions	Stop Date*

_____	_____	_____	___/___/____
Prescriber's signature**	Clinic address	Clinic phone number	Date signed

_____	_____	___/___/____
Parent/Guardian signature (Agreed to above statements)	Phone number	Date Signed

_____

Self-administration additional information

*This agreement is valid for one (1) school year. A new form will be needed during yearly registration.
[A separate form must be completed for each self-administered medication]

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