

505.4E1 Student Medication Exhibits

**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF
PRESCRIPTION MEDICATION**

Student name:	
School/grade:	
Date:	
Name of medication:	
Reason for medication:	
Dosage:	
Time to be administered:	
Length of time to be given:	
Signature of prescribing physician:	
Signature of parent/guardian:	
Special instructions:	

This prescription must be furnished by parent or guardian in a container properly labeled by a pharmacist or physician.

SELF-ADMINISTRATION FOR ASTHMA OR OTHER AIRWAY
CONSTRICTING MEDICATION OR EPINEPHRINE AUTO-INJECTOR
Administrative Procedures

The following must occur for a student to self-administer asthma or other airway constricting disease medicator or for the student with a risk of anaphylaxis to self-administer an epinephrine auto-injector.

- The parent/guardian must provide a signed, dated authorization for student medication self-administration.
- Parent/guardian provides a written statement from the student's licensed health care professional (a person licensed under chapter 148 to practice medicine and surgery or osteopathic medicine and surgery, an advanced nurse practitioner licensed under chapter 152 or 152E and registered with the board of nursing, or a physician assistant licensed to practice under the supervision of a physician as authorized in chapters 147 and 148C containing the following::
 - Purpose of the medication
 - Prescribed dosage
 - Times or special circumstances under which the medication is to be administered
- The medication is in the original, labeled container as dispensed or the manufacturer's container containing the student name, name of the medication, directions for use and date.
- Authorization is renewed annually. If any changes occur in the medication, dosage or time of administration, the parent is to notify school officials immediately. The authorization shall be reviewed as soon as practical.

Provided the above requirements are fulfilled, the school shall permit the self-administration of medication by a student with asthma or other airway constricting disease or the use of an epinephrine auto-injector by a student with a risk of anaphylaxis while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, may possess and use the student's medication while in school, at school-sponsored activities, under the supervision of school personnel, and before or after normal school activities, such as in before or after-school care on school-operated property. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn by the school or discipline may be imposed.

Pursuant to state law, the school district and its employees are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by the student. The parent or guardian of the student shall sign a statement acknowledging that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by Code 280.16.

PARENTAL AUTHORIZATION FOR ASTHMA OR AIRWAY
CONSTRICTING MEDICATION SELF-ADMINISTRATION

Name of Student: _____ Birthdate: _____

School: _____ Date: _____

- 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 that the medication must be in its original, labeled container as dispensed or the manufacturer's labeled container, containing the student's name, name of the medication, directions for use, and date.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for 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.

Additional information:

Parent/Guardian Signature

Date

Parent/Guardian Address

Phone Number(s)

REVIEWED and APPROVED: 12/14/20

**PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE
ADMINISTRATION OF MEDICATION TO STUDENTS**

Student Name: _____ Grade: _____ Date: _____

School: _____ Date of Birth: _____

It is necessary that this student receive the following medication:

(Name of medication)	(Dosage)	(Time)
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Beginning on _____ and continuing through _____.

!REQUIRED!

In the event of a late start or early dismissal, I authorize the school to:

_____ Give the medication (initial)

_____ Withhold the medication (initial)

_____ Other: _____

At the end of the year or when this medication is no longer needed at school:

_____ Send medication home with student (initial).

_____ Parent will pick up medication from school (initial).

Confidential Release of Information Consent

I hereby request the Muscatine School District, or its authorized representative, to administer the above-named medication to my child named above. I also authorize, as needed, the sharing of information relating to my child’s health, (student’s name) _____ between the school nurse (or designee) and the health care provider, Dr. _____. I will also comply with the procedure listed below for the dispensing of medication at school.

1. Submit this authorization form to the principal or school nurse.
2. Prescription drugs must be provided by the parent or legal guardian and must come in the original container which is marked with medication name, dosage, interval dosage and date after which no administration should be given.
3. Over-the-counter medications are discouraged during school hours. If it is necessary, over-the-counter medications must come in the original container and include written permission and instructions from the parent or guardian.
4. No medications will be provided by the school.
5. Submit a revised authorization form to the principal, school nurse, or designee when medication, dosage or instructions change.

(this form continued on next page)

DESIGNATED CARE PROVIDER:

Dr. _____ Agency: _____ Phone: _____

Address _____ City: _____ State: _____

Parent/Legal Guardian Signature _____ Date: _____

Relationship to Student: _____ Daytime Phone: _____

Alternate Daytime Phone: _____