ASTHMA/ANAPHYLAXIS MEDICATION SELF-ADMINISTRATION FORM

Student Name: _____ **Grade:** _____

The Missouri Safe Schools Act of 1996 (Pupils and Special Services Section 167.627, revised August 28, 2009) provides for students to carry and self-administer life-saving medications when the following criteria are met:
1) Written authorization by the parent/guardian
2) Medical history of student's asthma or anaphylaxis on file at the school
3) Written asthma action plan/individual health care plan on file at school
4) Written authorization from the prescribing health care provider that child has asthma or is at risk of having anaphylaxis, has been trained in the use of the medication and is capable of self-administration of the medication.

THIS MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR

MEDICATION NAME _____ Dose _____ Time or Interval_____
Route/Inhalation device _____ Instructions_____
_____

IMPORTANT NOTE: May repeat use of short-acting bronchodilator dose 2-6 puffs (i.e. Albuterol) with a spacer/spacer with mask every 20 minutes for 2 treatments if asthma symptoms are not improving (Expert Panel Report-EPR3, 2007 National Asthma Guidelines). Notify school staff if one dose fails to relieve symptoms.

MEDICATION NAME _____ Dose _____ Time or Interval _____
Route/Inhalation device _____ Instructions _____
_____

If Epinephrine, notify staff immediately when used. May repeat dose of epinephrine in 10-15 minutes if symptoms are not resolving. ALLERGIES: list known allergies to medications, foods, insects, latex or air-borne substances: _____
_____

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms in 20 minutes or does not sustain my child for at least 3 hours. My child understands to notify school staff immediately if epinephrine is used so 911 can be called. I acknowledge that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child or the administration of such medication by school staff.

Signature of parent or legal guardian _____ **Date:**_____

Parent/Guardian:
Name: _____Home phone: _____ Cell phone:_____
Address: _____Work phone: _____
Name: _____Home phone: _____Cell phone: _____
Address: _____ Work phone: _____

Emergency Contact:
Name: _____ Phone: _____

I, a licensed health care provider, certify that this child has a medical history of asthma and/or anaphylaxis, has been trained in the use of the listed medicine, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms in 20 minutes or sustain the child for at least 3 hours. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

Signature of Health Care Provider _____ **Date**_____

Health care Provider (Please Print):
Name:_____
Fax: _____
Phone:_____
Address: _____City: _____ Zip: _____