

**School Medication Permission
For Self-Administration of Asthma or other Airway
Constricting Disease Medication**

Student Name: _____

Grade: _____

Address: _____

Phone: _____

Date of Birth: _____

School Building: (E / MS / HS) _____

I hereby request that the Center Point-Urbana Community School District employees allow the above named child to carry and self administer asthma or other airway constricting disease medication.

The Center Point-Urbana Community School District and its employees, in accordance with Senate File 2177, Section 1, New Section 280.16 *Self-Administration of Asthma or other Airway Constricting Disease Medication*, are to incur no liability, except for gross negligence, as a result of any injury arising from self-administration of medication by a student. The Center Point-Urbana Community School District and its employees acting reasonably in good faith shall incur no liability for any improper use of medication as defined in this section or for supervising, monitoring, or interfering with a student's self-administration or medication as defined in this section.

The parent/guardian shall immediately notify the school of any changes in the student's medical condition or medication changes.

Parent/Guardian Signature

Date

Physician's Authorization and Information

Diagnosis: _____

Medication: _____

Route: _____

Dosage: _____

Time: _____

Side Effects: _____

Date of Rx: _____ Discontinuation Date: _____

Other medication student is receiving: _____

Physician's Signature/Licensed Prescriber's Number

Date

Office Phone