Olathe
PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF EMERGENCY ASTHMA/ALLERGY MEDICATION

PART A: *Parent/Guardian to Complete*

Name of Student: ______________________ Date of Birth: ________ School: _______ Grade: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed below. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

I further acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning:

- The prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube);
- Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule);
- Student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom), and
- Other pertinent issues related to the student's diagnosis, condition, or treatment.

_________________________ _________________________ ______________

Parent /Guardian Signature | Parent (Printed Name) | Today's Date

Part B: *Physician to Complete*

Medication	Purpose	Dosage	Time / Frequency
_________________	_______________________	____________	___________________
_________________	_______________________	____________	___________________
_________________	_______________________	____________	___________________

Conditions & special circumstances for use: ____

Length of time medication is to be administered: ____

_________________________ _____________________ _____________________

Physician Signature | Physician (Printed Name) | Today's Date

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Physician Phone Number

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Part C: *School Nurse to Complete*

School Nurse Review of order and procedure with the student. Completed _________________________

Date of Review

RETURN TO SCHOOL NURSE

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