School Year ___/___

Butler Area School District

Rescue Medication Self-Administration Authorization Form

Must be completed each school year.

Student Name____ DOB________________ Grade____ Room___________

Rescue medications ~ Albuterol Inhalers/ Epinephrine Auto Injectors

Criteria for self-administration of rescue medications. The student must have the ability to:

1. _____Respond to and visually recognize his/her name.
2. _____Identify his/her medication.
3. _____Demonstrate proper technique for self-administering his/her medication.
4. _____Sign his/her medication sheet to acknowledge having used the medication.
5. _____Demonstrate a cooperative attitude in all aspects of self-administration of medicine.

**Students who fail to meet any one of these criteria cannot self-administer rescue medication. **

TO BE COMPLETED BY PRESCRIBER: Please complete all parts and sign below

Diagnosis/Condition________________________________ Medication____________________________________

Dosage____Frequency______________________________________

I have instructed _____________________________ in the correct way to use the above medication, and it is my professional opinion that he/she has the knowledge and skills to possess and safely self-administer this medication in school and should be permitted to carry and use the medication by himself/herself without supervision.

Printed physician's Name______________________________________Phone number_______________________

Physician's Signature____ Date________________________________

TO BE COMPLETED BY PARENT: Please complete all parts and sign below

Hold Harmless Statement: I, as the parent/guardian of the above-named student, do hereby release, discharge and hold harmless the Butler Area School District, its agents, and employees from any and all liability, in any claim whatsoever for the benefits or consequences of the above-listed medication when it is physician prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for insuring that the medication is taken/given correctly and agree to release, discharge, and hold harmless the Butler Area School District, its agents and employees from any and all claims whatsoever resulting in the students failure to take the medication as prescribed. I am aware that any improper use/sharing of the above-named medication will result in the immediate confiscation and loss of privilege to self-administer if the medication policy is violated.

Authorization for Release of Information: I give my permission for the release/exchange of pertinent information between the school nurse and the licensed prescriber's office by telephone, mail, or electronic exchange regarding all of the medical/medication information described on this form concerning my child.

Self-Administration: My child has been instructed in the correct way to use the above medication and should be permitted to carry and use that medication independently, without supervision. I will provide back-up medication to be kept in the Health Office.

Parent/Guardian Name____Phone_____________________________

Work Phone____________________________________Cell phone/pager__________________________________

TO BE COMPLETED BY STUDENT: Please complete and sign below

I agree to be solely responsible for my medication and to follow directions for its use as ordered by my physician, as well as by my School District's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my medication.

Student's Signature____Date_______________________