LANSING
UNIFIED SCHOOL DISTRICT 469

Authorization For Self-Administration of Medication for Asthma/Allergies K-12 And Insulin For Grades 6-12

PART A- *Parent/Legal Guardian to Complete*

Name of Student: _____Date of Birth: _____ Grade/Teacher: _____

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

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PART B - *Physician to Complete*

Current Diagnosis(es): _____

Medication	Purpose	Dosage	Time/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Conditions & Special Circumstances for use: _____

This student is authorized to self-administer and has been instructed in self-administration of this medication. He/she has the skill, judgment and maturity to self-administer this medication.

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

_____
Physician Phone Number

PART C: *School Nurse to Complete*

School Nurse Review of order and procedure with student. Complete satisfactorily: _____
Date of Review