BLUE SPRINGS ASTHMA & ANAPHYLAXIS MEDICATION SELF-ADMINISTRATION FORM

Student Name: _____ Birthdate: _____ Grade_____ School Year: _____

According to Missouri Law, students may be allowed to carry and self-administer prescribed medication while at school, at a school-sponsored activity and in transit to or from school or school-sponsored activity when they meet the following requirements:

- A physician prescribed the medication for use by the student and instructed the student in the correct and responsible usage of the medication.
- The student has demonstrated to the student's licensed physician or the licensed physician's designee, and the school nurse the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered.
- The student's physician has approved and signed a written treatment plan for managing the student's chronic health condition, including asthma or anaphylaxis episodes and for medication for use by the student. Such plan shall include a statement that the student is capable of self-administering the medication under the treatment plan. The plan will be effective only for the same school year it is granted and must be renewed each year.
- The student's parent/guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan and a statement acknowledging the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

Emergency Medication: Please fill out medication(s) as prescribed:

☐ Epinephrine 0.15 mg auto-injection pen ****Student must notify school staff immediately if used and 911 will be called****

☐ Epinephrine 0.3 mg auto injection pen ****Student must notify school staff immediately if used and 911 will be called****

☐ Rescue Inhaler: _____

☐ Other: _____

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER

I certify that the above-named student has a medical diagnosis of _____ and has been trained in the correct and responsible use/administration of the medication(s) listed above and is capable of carrying and self-administering the listed medication. I have provided the student with a signed treatment plan to manage their chronic health condition. The student should notify school staff if the medication(s) are used but condition is not improved. The student has been instructed on the hazards of sharing medication with others and agrees to use medication as prescribed.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone Number: _____

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER

I, the parent/guardian of the above named student give permission for my child to carry and self-administer the above listed medication(s). I have instructed my child to notify school staff if medications are used but condition is not improved. My child understands his/her symptoms and when to use his/her medication. I understand the district's medication policy/guidelines and will always provide my child with medication in the original container with an attached prescription label. My child understands the hazards of sharing medication with others and has agreed to refrain from this practice. I understand that, absent any negligence, the school shall incur no liability as a result of any injury arising from the self-administration of medication by my child.

Parent Signature: _____ Date: _____