School District 51
MESA COUNTY VALLEY
Every student, every day, learning for life!

NURSING SERVICES
Hawthorne Building
410 Hill Ave, Grand Junction, CO 81501

AUTHORIZATION FOR ASTHMA MEDICATION AT SCHOOL

The "Colorado Schoolchildren's Asthma and Anaphylaxis Health Management Act" states that a student with asthma, severe allergies, or other related, life-threatening condition may possess and self-administer medication to treat his/her asthma, anaphylaxis, or other related life-threatening condition if the following conditions are met: 1) the physician signs below authorizing the student to carry and self-administer this medication 2) the parent and student sign a contract with the school nurse acknowledging the risks and responsibilities associated with carrying and self-administering medication at school.

Student Name:	Birthdate:	School:	Grade:

Physician/Primary Care Provider (please initial and sign below):

Provider Name:		Phone:
Name of Medication:		Dosage, duration between doses:
Reasons for giving:	Start date:	End date:
Expected action and potential side effects (write on reverse side or attach an additional page):		

_____ I do not recommend that this student be allowed to carry and self-administer this asthma medication at school. I authorize MCVSD #51 personnel, which may include non-nursing staff, to administer this medication in accordance with the above instructions.

OR

_____I certify that the above named student has been instructed by me or by a member of my staff and has demonstrated the skill level necessary to carry and safely self-administer this medication at school.
_____In the event of a situation in which the student is unable to self-administer the above medication, I authorize MCVSD #51 trained staff, which may include non-nursing personnel, to administer this medication in accordance with the above instructions.

Signature:	Date:

Parent/Legal Guardian (please initial and sign below):

Parent/Legal Guardian Name:	Phone:

_____I prefer that my student's medication for asthma be kept in the school Health Office. I hereby give permission for school personnel to administer the above medication as ordered. I understand that the medication may be administered by non-nursing staff of MCVSD #51. I give permission for school staff/school nurse to contact the health care provider above about this medication and share the information with appropriate staff.

OR

_____I give permission for my child to carry and self-administer the above medication. I give permission to school staff/school nurse to contact the health care provider above about this medication and to share the information with appropriate school staff. I will be contacted by the Registered Nurse and agree to read and sign the "Contract for Student to Carry and Self administer Medication for Asthma at School"

Signature:	Date: