Student's Name: _____ Birth date: _____ Grade: ____

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

Name of Medication	Dosage	Methods of Administration	Time of Day to be Taken

Reason for medication to be given during school hours:

Anticipated action:
Possible side effects of medication:
Emergency procedure in case of serious side effects:

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for the period commencing with the day of , 20__, as there exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel.

Date of Signature: _____ Physician's/Dentist's Signature: _____
Telephone Number: _____ Printed Name: _____
Address: _____

THIS SECTION TO BE COMPLETED BY THE PARENT / GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to administer the above identified medication to the above identified student in accordance with the prescription or doctor's instructions for the period beginning the _____ day of _____ , 20 __ , through the ____ day of _____ , 19 __ (not to exceed one school year).

Medication will be supplied to the school in the original container.

_____ _____
Date of Signature Signature

Telephone Number: Home--_____ Work--_____

3 COPIES: STUDENT FILE, TEACHER, AND ADMINISTRATOR

Montana Authorization to Possess or Self-Administer
Asthma, Severe Allergy, or Anaphylaxis Medication

For this student to possess or self-administer asthma, severe allergy, or anaphylaxis medication while in school, while at a school sponsored activity, while under the supervision of school personnel, before or after normal school activities (such as while in before-school or after-school care on school-operated property), or while in transit to or from school or school-sponsored activities, this form must be fully completed by: 1) the prescribing physician/ physician assistant/advanced practice registered nurse, and 2) an authorizing parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or legal guardian.

Student's Name: _____ School: _____
Sex: (Please circle) Female/Male City/Town: _____
Birth Date: _____/_____/_____ School Year: _____ (Must be renewed annually)

Physician's Authorization:
The above named student has my authorization to carry and self-administer the following medication:
Medication: (1) _____ Dosage: (1) _____
(2) _____ (2) _____

Reason for prescription(s): _____
Medication(s) to be used under the following conditions (times or special circumstances): _____
_____

I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision. I have formulated and provided to the parent/guardian or caretaker relative a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician/PA/APRN Phone Number Date

Authorization by Parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or Guardian

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

I acknowledge that the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.
I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which my child has access in the event of an asthma, severe allergy, or anaphylaxis emergency.

I have provided the following backup medication:
_____.

I understand that in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad, and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and the medication that is not picked up will be disposed of.

I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian, Caretaker Relative Signature: _____ Date: _____
(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider) See, generally, Mont. Code Ann. § 20-5-420.