Bellevue Public Schools

Self-Management of Asthma and Severe Allergy (Anaphylaxis) at School Consent/Release Form

NRS 1049 - 3/23

A new action plan is required each school year to be completed on or after May 1 and must be accompanied by:

- **Signed physician authorization for self-management of asthma/anaphylaxis at school.**
- **Current written medical management plan.**

Parent/Guardian: By signing below, you acknowledge the following:

1. You are requesting that your student be allowed to self-manage his/her asthma or allergy condition at school.
2. You have confidence that your student has the knowledge and skills needed to self-manage his/her asthma or allergy condition at school.
3. You understand that you are not required to make this request on behalf of your child. Your child may utilize the health office for asthma or allergy cares. Your child may request assistance from qualified school health personnel at any time during the school day.
4. If your student injures school personnel or another student as a result of misuse of asthma or allergy supplies, you shall be responsible for any and all cost associated with such injury.
5. The school and its employees are not liable for any injury or death arising from a student's self-management of his/her asthma or allergy condition.
6. You will indemnify and hold harmless the school and its employees and agents against any claim arising from a student's self-management of his/her asthma or allergy.
7. We strongly recommend you provide an extra supply of your student's medication to be kept in the health office as a back-up supply.

_____ _____

Parent/Guardian Printed Name Student Printed Name

_____ _____

Parent/Guardian Signature Date

Physician Authorization

I authorize _____ to self-manage his/her asthma or anaphylaxis condition.

I have participated in the development of the student's asthma medical management plan.
After review and assessment, the student understands and has the ability to self-manage his/her asthma or anaphylaxis condition.

_____ _____

Physician Printed Name Physician Signature

_____

Date

Student: By signing below, you agree that you understand:

1. You must not share or allow another student to handle your medications or supplies.
2. You agree to use your medication in a responsible manner and in accordance with your physician's instructions.
3. If you need your medications, and you do not feel better after using them, you will notify school staff that you need help, or you will come to the school health office.

_____ _____

Student Signature Date