ASTHMA INHALER SELF-ADMINISTRATION MEDICATION FORM

_____ _____ _____
Student's Name Grade and Homeroom Date

To be completed by physician, certified nurse practitioner or physician assistant:

_____ _____ _____ _____
Diagnosis Name of Inhaler Dose Frequency

Length of time medication should be taken: _____

Side effects of the medication: _____

Is this student qualified to self-administer this medication? ( ) Yes ( ) No

_____
Health Care Provider Signature

***To be completed by the parent or guardian*:**

As the parent/guardian of the above named student, I give permission for the self-administration of the above named inhaler. I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____
Date Parent Signature

***To be completed by the student*:**

I agree to solely be responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I agree to not share the inhaler with any students. I am aware that any abuse of this privilege will result in the confiscation of my inhaler. If I use my inhaler at school, I will notify the school nurse as soon as possible.

_____ _____
Date Student Signature

To be completed by the school nurse:

To self medicate, the student must be able to: (check all that apply)

___ Respond to and visually recognize his/her name.
___ Identify his/her medication.
___ Demonstrate the proper technique for self-administering his/her medication.
___ Sign his/her medication sheet to acknowledge having taken the medication.
___ Demonstrate a cooperative attitude in all aspects of self-administration of medication.

The above named student has demonstrated the ability to self-administer the physician prescribed asthma medication, as indicated by the criteria above.

_____ _____
Date School Nurse Signature