

## ASTHMA INHALERS – SELF-ADMINISTRATION BY STUDENTS

Student's Name	Grade	Date
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To self medicate, the student must be able to: (check all that apply)

- \_\_\_\_\_ 1. Respond to and visually recognize his/her name.
- \_\_\_\_\_ 2. Identify his/her medication.
- \_\_\_\_\_ 3. Demonstrate the proper technique for self-administering his/her medication.
- \_\_\_\_\_ 4. Sign his/her medication sheet to acknowledge having taken the medication.
- \_\_\_\_\_ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of Medication	Dosage	Frequency
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Date	Signature (Physician)
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The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

Date	Signature (Certified School Nurse)
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As the parent/guardian of above named student, 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/Guardian Signature
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I agree to be solely 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 am aware that any abuse of this privilege will result in the confiscation of my inhaler.

Date	Student's Signature
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