st. croix preparatory ACADEMY

Self–Administration of Asthma Medication Authorization
School Year _____

To Be Completed By Prescribing Health Professional

It is my professional opinion that _____ is capable of carrying & self-administering the following medication:

Medication	Dose	Route	Frequency
Medication	Dose	Route	Frequency

I recommend self-administration of this medication for the treatment of asthma.

Symptoms and/or peak flow should be checked in the school health office:
____daily ____weekly ____monthly ____other _____.

Comments: _____

Discontinuation date: _____

_____
Health Care Provider Signature

_____ _____ _____
Printed Name Phone # Date

To Be Completed By Parent / Guardian

I hereby give my permission for my child to self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to my child's health / medications between the school nurse and the prescribing health professional / clinic.

_____ _____
Signature of parent/guardian Date

_____ _____
Work phone # or other daytime phone number Cell phone number

Student Agreement

I agree to:

- ❑ use correct inhaler technique (demonstrate to nurse)
- ❑ not allow anyone else to use my medication
- ❑ maintain a written record of my medication administration at school (e.g. in my planner, notebook, etc.)
- ❑ keep a current supply of my medication located (e.g purse, backpack, etc.) _____
- ❑ keep spare medication in the nurse's office
- ❑ check-in with the school nurse __daily __weekly __ monthly __ other :_____
  (note what day of the week and time_____)
- ❑ notify the school nurse or_____ under the following circumstances;
  _____ I need to take my quick-relief medication (albuterol) more often than 2 x a week during the day or more than 2 x a month at night
  _____ I have asthma symptoms after exercise, sports or physical education class
  _____ My symptoms don't go away or get worse after taking my medication
  _____ I suspect that I am having side effects from my medication
  _____ My peak flow reading or symptoms is/are in the yellow or red zone
  _____ Other _____
- ❑ follow my health care provider's orders
- ❑ refill my prescriptions before they run out (or help remind my parent/guardian to do so)
- ❑ see my health care provider for preventive "Well Asthma Check-ups" at least twice a year
- ❑ call my health care provider if I am having symptoms that don't get better after a day or so

I know or will find out:

- ❑ who my health care provider is and how to contact her / him
- ❑ where my pharmacy is and how to contact

_____ _____
Signature of Student Date

To Be Completed By Licensed School Nurse

- ❑ This student has demonstrated mastery related to his / her asthma medication and self-care skills.
- ❑ This student needs reinforcement of his/ her asthma medication and self-care skills.
- ❑ This student may self-carry and should check in with me as described above.
- ❑ _____

_____ _____
Signature of Licensed School Nurse Date

NOTE: If the school nurse does not concur with the health care provider's instructions after assessing the competencies of the student, the school nurse will contact the health care provider to attempt to agree upon a plan. In the event agreement is not reached, the parents may refer the case to the Chief Financial Officer at 395-5902 for resolution. Permission for the self-administration of medication may be suspended if the student is unable to maintain the procedural safeguards established in the above agreement. If there is disagreement related to this procedure, the case may be referred to the Chief Financial Officer for resolution.