

Self-Administration of Asthma Medication Authorization School Year _____

To Be Completed By Prescribing Health Professional			
		is capable of carrying & self-adn	ninistering the
Dose	Route	Frequency	
Dose	Route	Frequency	
n of this medication for the t	reatment of asthma.		
	Phone #	Date	
	Dose Dose n of this medication for the t ould be checked in the scho ymc	Dose Route Dose Route n of this medication for the treatment of asthma. ould be checked in the school health office: y monthly	Dose Route Frequency n of this medication for the treatment of asthma.

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

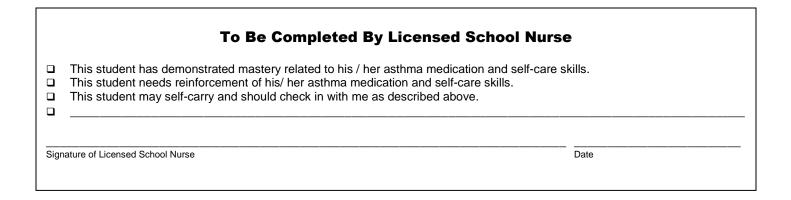
Date

Work phone # or other daytime phone number

Cell phone number

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Student Agreement			
e 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 nursedailyweekly monthly other :			
(note what day of the week and time)			
check-in with the school nursedailyweekly 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 			
call my health care provider if I am having symptoms that don't get better after a day or so			
v or will find out:			
who my health care provider is and how to contact her / him			
where my pharmacy is and how to contact			
re of Student 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.