FARIBAULT PUBLIC SCHOOLS

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: ****If student is not able to self-administer initial here_____****

Medication	Dose	Route	Frequency
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I recommend administration of this medication for the treatment of asthma.

Symptoms and/or peak flow should be checked in the school health office: ******Please include Asthma Action Plan******

___daily ___weekly ___monthly ___other:_____

Comments:_____

Discontinuation date:_____

_____ _____
Health Care Provider Signature Date

_____ _____
Printed Name Phone #

To Be Completed By Parent/Guardian

I hereby give my permission for my child to self-administer the above medication at school as prescribed by my child's prescribing health professional. I authorize reciprocal release of information related to my child's health/medications between the school nurse and the prescribing health professional/clinic. I understand that the school nurse may decide that my child is not able to self-administer medication. If that is the case the school nurse will contact me and explain the reason.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Daytime Phone # Cell Phone #

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 in (e.g. purse, backpack, etc.) _____
- ☐ Keep spare medication in the school health office
- ☐ Check in with the school nurse ___daily ___weekly ___monthly ___other_____ (note day of week and time) _____
- ☐ Notify the school nurse under the following circumstances:
  - I need to take my quick relief medication more often than twice a week during the day or more than twice 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 medication
  - I suspect that I am having side effects from my medication
  - My peak flow reading or symptoms are in the yellow or red zone
  - Other, _____
- ☐ Follow my health care provider's orders
- ☐ Refill my prescriptions before they run out/expire (or help remind my parent/guardian to do so)
- ☐ See my health care provider for preventive "well asthma check-ups" once a year or as directed by my provider
- ☐ 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 him/her
- ☐ Where my pharmacy is and how to contact them

I understand that permission for the self-administration of medication may be suspended at any time if I am unable to maintain the above safeguards.

_____ _____

Student Signature Date

To Be completed by School Nurse

- ☐ This student has demonstrated mastery related to his/her asthma medication and self-care skills. They may self-administer and carry medication. They should check in with the school nurse as described above.
- ☐ This student needs reinforcement of his/her asthma medication and self-care skills. The student will keep medication in school health office and work with the school nurse to develop self-care skills. School nurse will reassess student periodically to self-carry and self-administer medication

_____ _____

Signature of School Nurse Date