Self-Administration of Asthma Inhaler Student Agreement

Name: ________________________________________________  Grade: _____  Inhaled Medication: _____________________________________  Date:  _____

I agree to:

• Follow my prescribing health professional’s medication order.
• Use correct medication administration technique.
• Not allow anyone else to use my medication under any circumstances.
• Keep the medication with me in school and on field trips.
• Inform the school nurse of the time and reason for taking the inhaler.
• Notify (or have someone else notify) the school nurse immediately if the following occurs:
  o My symptoms continue to get worse after taking the medication.
  o My symptoms reoccur within 2-3 hours after taking the medication.
  o I think I might be experiencing side effects from my medication.
  o Other __________________________________________________
• I understand that permission for self-administration of medication may be discontinued if am unable to follow the safeguards established above.

___________________________  __________
Signature of Student             Date

___________________________  __________
Signature of Parent/Guardian/Relative Caregiver                      Date

☐ Student verbalizes dose
☐ Student demonstrates proper technique
  ▪ Removes cap and shake if applicable
  ▪ Attaches spacer if applicable
  ▪ Breaths out slowly
  ▪ Presses down inhaler to release medication
  ▪ Breaths in slowly
  ▪ Holds breath for 10 seconds
  ▪ Repeats as directed

☐ Student verbalizes safe use
☐ Student verbalizes symptoms/signs of when medication is needed & when to notify school nurse
☐ Parent permission to self-administer

The student has demonstrated knowledge about the proper use of his/her medication and necessary permissions (parent and licensed healthcare provider) are on file.

___________________________  __________
Signature of School Nurse             Date