Legacy Christian Academy
Phone: 763-427-4595 Ext 208
Fax: 763-427-3398

School Year_____

# Authorization for Self-Administration of Inhaled Medication at School

## PARENT/PHYSICIAN

When a prescribing health professional, parent/guardian, student and school nurse agree that self-administration of inhaled medication is appropriate for an individual student, the procedure must be done safely, carefully, and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school. The inhaled medication must be appropriately labeled by a pharmacist or the prescribing health professional.

A student, who has safely demonstrated the skills necessary for using an inhaler, will be allowed to self-administer the inhaled medicine once the student agreement is signed.

This form must be completed by the prescribing health professional and parent/guardian and returned to the school nurse. Orders must be renewed annually or whenever medication, dosage, or administration changes.

## PARENTAL AUTHORIZATION

I hereby give permission for my child to self-administer his/her inhaler medication at school as prescribed by my child's prescribing health professional. I give my medical provider and Anoka Hennepin permission to release and obtain information from each other as necessary. This authorization takes effect the day that I sign it. It expires one year from the date of my signature. I understand that I may change this authorization at any time.

_____ _____

Signature of Parent/Guardian * Date

* More information on back of form

## TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I believe that _____is capable of self-administering the
(Student's Name)
following inhaled medication:

_____ _____ _____

Medication Dose Frequency

I recommend self-administration of this inhaled medication for the treatment of_____

Student is knowledgeable about the inhaled medication and how to administer it.
Student has the skills to safely possess and use an inhaler.
Student may self-administer the inhaled medication.

_____ _____

Print or type Name of Physician/Licensed Prescriber Physician's/Licensed Prescriber's Signature

_____ _____ _____

Clinic Address Phone Number Date

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## STUDENT AGREEMENT

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Maintain a written record of my medication administration at school.
- Not allow anyone else to use my inhaled medication.
- Keep a supply of my inhaled medication with me in school and on field trips.
- Keep spare inhaler in the Health Service.
- Notify the health office personnel if the following occurs:
  - ❑ My symptoms continue or get worse after taking the inhaled medication.
  - ❑ My symptoms reoccur within 2-3 hours after taking the inhaled medication.
  - ❑ I suspect that I am experiencing side effects from my medication.
  - ❑ Other_____.
- I understand that permission for self-administration of inhaled medication may be suspended if I am unable to follow the procedure outlined.

_____

Signature of Student Date

This student has demonstrated knowledge about and proper use of his/her inhaler.

_____

Signature of Licensed School Nurse Date

I have read the above student agreement.

_____

Signature of Parent/Guardian Date