SLP
BLAINE | FRIDLEY
SPRING LAKE PARK
SPRING LAKE PARK SCHOOLS

Health Services
Self-Administration of Medication

School Year: _____

To be completed by prescribing health professional

It is my professional opinion that _____ is capable of carrying and self-administrating the following medication(s):

Medication	Dose	Route	Frequency
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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 _____Daily _____ Monthly _____ Other: _____

Comments: _____

_____

_____

Discontinuation date: _____

_____
Health Care Provider Signature

Print Name	Phone number	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 number or other daytime phone number	Cell phone number

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Health Services

Self-Administration of Medication

Student Agreement

I agree to:

- Follow my prescribing health professional's medication orders
- Use correct medication administration techniques
- Maintain a written record of my medication administration at school
- Not allow anyone else to use my medication
- Keep a supply of my medication with me in school and on field trips
- Notify the school nurse or health office personnel if the following occurs:

    1. My symptoms continue to get worse after taking the medication
    2. My symptoms reoccur within 2-3 hours after taking the medication
    3. I suspect that I am experiencing side effects from my medication
    4. Other:_____

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

_____ _____

Signature of Student ***Date***

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

_____ _____

Signature of Health Care Specialist ***Date***