Memorandum to Parent/Guardian(s)

To: Parent/Guardian(s) of Children using Inhalers at School:

There are two options available for the child who needs to use an inhaler at school.

_____ **Option #1** Child will be allowed to carry his/her own inhaler and use it without supervision.

Advantage: The medication is immediately accessible. (A spare inhaler must be provided by the parent/guardian to be kept in the health office where it will be available should the child forget his/hers.)

To utilize this option, please complete the **Contract for Permission to Carry Inhalers** and the **Authorization and Permission for Administration of Medication Form** (completed and signed by the physician and parent/guardian) and return to the health office with the spare inhaler.

_____ **Option #2** The child comes to the health office where the inhaler is kept, and uses it under supervision.

Advantage: This will ensure that the medication is used correctly, in the proper amount, and the doses will be documented.

To utilize this option, the child's physician must complete and sign the **School Medication Authorization Form**. The parent/guardian must complete and sign the **Parental Authorization** section. The form and properly labeled medication should be returned to the health office.

All medications brought to school must meet the requirements as outlined in the school district's medication administration policy.

DISTRICT 20 HEALTH SERVICES

Greenbrook Elementary School & Early Childhood Center
630-894-4409 Nurse Phone
630-894-4544 Main Office
630-289-6183 Fax

Waterbury Elementary School
630-894-4211 Nurse Phone
630-893-8180 Main Office
630-539-2316 Fax

Spring Wood Middle School
630-894-4044 Nurse Phone
630-893-8900 Main Office
630-894-9658 Fax

Updated 09/2019

Student Agreement to Carry Inhaler

1. Student has demonstrated the correct use of the inhaler to the health care provider and school personnel.
2. Student agrees to **NEVER** share the inhaler with another person.
3. Student agrees that if there is not marked improvement after two puffs, he/she will notify a teacher or other responsible adult who will see further intervention as outlined in the student's Asthma Care Plan.

Student Signature: _____ Date: _____

I give permission for my child _____ to carry the inhaler described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication of my child's condition.

NAME OF MEDICATION	DOSE	FREQUENCY OF USE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

(R-05-17)

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Updated 09/2019

Physician Request for Self-Administration of Medication

_____ _____
Name of Student Birthdate

_____ _____
City Zip Telephone Number

TO:

Principal: _____

School: _____

The above named pupil has _____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

_____
Name of Medication Type of Medication

_____
Dosage Time(s) to be given

_____
Possible Side Affects

I certify that _____ has been instructed in the use and self-administration
(Name of Student)

of _____
(Name of Medication)

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

_____ _____
Phone Number of Physician Signature of Physician Date

_____ _____
Address of Physician Print Name of Physician Date

(R-05-17)

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I, _____ (parent/guardian), confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Keeneyville School District 20 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employee and agents of the School District), lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICAITON TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

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