LEE'S SUMMIT R-7 SCHOOL DISTRICT

INHALER SELF-ADMINISTRATION PROCEDURE FORM

THIS MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT YEAR

Student Name: _____**DOB:**_____ **School:**_____
Parent/Guardian: _____**Phone:**_____
Physician: _____**Phone:**_____

Quick Relief Medications

- ❑ Albuterol inhaler 2 puffs every 4-6 hours as needed for cough/wheezing
- ❑ Albuterol inhaler 2 puffs 15-20 minutes before exercise if needed
- ❑ Other_____
  _____

❑ Physician has provided Personal Asthma Action Plan **OR** ❑ Student will follow School Asthma Treatment Plan

❑ Personal Best, if known: FEV1_____ PEF_____

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER: I certify that the above named student has a medical history of asthma, has been instructed in the proper self-administration of the medication(s) listed above and is judged to be capable of carrying and self-administering the listed medication(s). The student should notify school staff if one dose of medication fails to relieve their asthma symptoms in 20 minutes or sustain the student for at least 3 hours. This student understands the hazards of sharing medications with others and has agreed to refrain from this practice.

Physician Signature: _____**Date**:_____

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER: I, the parent/guardian of the above named student, give permission for this student to carry and self-administer the above listed medication(s). I have instructed my student to notify school staff if one dose of medication fails to relieve asthma symptoms in 20 minutes or sustain my student for at least 3 hours. I acknowledge that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my student or the administration of such medication by school staff.

Parent/Guardian Signature: _____**Date:** _____

SCHOOL PLAN: School will follow Personal Asthma Action Plan if parents have provided one to the school. If no Personal Asthma Action Plan has been provided, then the School Asthma Treatment Plan will be followed.

Student has Personal Asthma Action Plan in file: ❑ yes ❑ no

RESPONSIBILITIES FOR CARRYING INHALERS: (to be checked by the School Nurse)

YES	NO	
☐	☐	Student is able to identify signs and symptoms of asthma.
☐	☐	Student agrees to come directly to the Health Room if one dose of medication fails to relieve asthma symptoms in 20 minutes or does not last at least 3 hours.
☐	☐	Student provides a second inhaler to be kept in the health room. (This is recommended but not required)

School Nurse Signature: _____