

**LAMPETER-STRASBURG SCHOOL DISTRICT**

1600 Book Road  
P.O. Box 428  
Lampeter, Pennsylvania 17537

**Self-Administration of Medication Nurse Approval and Student Agreement**

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_ School Year: \_\_\_\_\_

**Asthma Inhaler:** \_\_\_\_\_

Student verbalizes purpose of medication?	
Student identifies specific symptoms and need for medication administration?	
Student is knowledgeable of dosage and frequency of use?	
Student is knowledgeable of how to use inhaler properly?	
Student knows side effects/adverse reactions to medication and verbalizes plan if reactions occur?	
Student verbalizes how to get help for self if symptoms persist or get worse after taking medication?	
An individual health plan or emergency plan has been developed?	
Student agrees to not let anyone use his/her inhaler?	
Plan to keep a spare inhaler in the health room (Recommended)	

**Epinephrine Pen – List Life Threatening Allergies:** \_\_\_\_\_

Student verbalizes purpose of medication?	
Student identifies specific symptoms and need for medication administration?	
Student is knowledgeable of how to use Epinephrine Pen?	
Student understands Emergency procedures once Epinephrine Pen is administered?	
An individual health plan or Emergency Plan has been developed?	
Plan to keep a spare Epinephrine pen in the health room (Recommended)	

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_