Providence

PROVIDENCE CHRISTIAN SCHOOL
ASTHMA INHALER SELF-CARRY AUTHORIZATION FORM

This order is valid only for school year (current)_____ unless revoked by the parent, physician, or school nurse or if the student fails to comply.

This form must be completed fully in order for a student to self-carry and administer his/her prescribed and pharmaceutically labeled asthma inhaler while at school, school-sponsored activities, or in transit to and from school or school-sponsored activities.

The following requirements must be met in order for your child to carry his/her inhaler at school:
☐ Section 1 must be completed and signed by the prescribing provider.
☐ Section 2 must be completed and signed by a parent or guardian.
☐ Section 3 must be completed by the student and verified by the School Nurse.
☐ The student must comply with all instructions and regulations associated with carrying and administering the inhaler.
☐ Prescription medication must be in an original container labeled by the pharmacist or prescriber.

Section 1 – Prescriber Authorization

Name of Student: _____

Date of Birth: _____ Grade: _____

Diagnosis: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of Administration: _____

If PRN, what frequency and symptoms:

_____

Relevant side effects: ❑ None expected ❑ Specify: _____

Dates Medication shall be administered from: _____ - _____ (M-Day-Year)

Prescriber please initial next to each statement:
_____ I confirm that this student has been fully instructed on the use of his/her medication including dose, frequency, technique, and side effects.
_____ This student has demonstrated the proper use of his/her inhaler in my office.
_____ I confirm that this student is capable of self-administering the prescribed medication **OR**

_____ I **DO NOT** recommend that this student be allowed to self-carry and administer the prescribed medication.

Prescriber Name/Title: _____ Telephone: _____

Address: _____

Prescriber Signature: _____ Date: _____

Providence

Section 2 – Parent/Guardian Authorization

Please initial next to each statement:

_____ My child has demonstrated proper use of his/her inhaler in my presence.
_____ My child understands his/her asthma triggers, symptoms, and treatment plan.
_____ My child understands the importance of letting school staff and parents know when he/she is having more difficulty than usual with asthma symptoms or episodes.
_____ My child understands that he/she is to keep inhaler with him/her at all times.
_____ My child understands that he/she should never share his/her inhaler with another student.
_____ I agree to provide the school office with an extra (back-up) rescue inhaler.
_____ I acknowledge that it may not be possible for the school staff to monitor or document doses, frequency, technique, or response of my child to the self-carried medication.
_____ I agree to provide a new authorization form if there is any change in the medication, dosage, administration time, or special instructions regarding the medication.
_____ I understand that the School Nurse will share information relevant to the prescribed medication as he/she determines appropriate for my child's health and safety.

I/We, the parents/guardians of _____ (student name), **give/do not give (circle one)** permission for him/her to self-carry and administer inhaled asthma medication.

As this inhaler is a parent-authorized and physician-prescribed medication, I/We, the parents/guardians of _____ (student name), relieve Providence Christian School or any employee of any responsibility for the benefits or consequences of this medication. I also acknowledge that Providence Christian School bears no responsibility for ensuring that this medication is taken.

Parent/Guardian Signature:_____ Date:_____

Section 3 – Student School Nurse Certification

Please initial next to each statement:

_____ I agree to use my inhaler as prescribed above. I understand my asthma triggers, symptoms, and treatment plan (verbalize to School Nurse).
_____ I understand the correct technique for administering my inhaler (demonstrate to School Nurse).
_____ I agree to keep my inhaler with me at school at all times, as well as a back-up inhaler in the office.
_____ I agree to go to the office whenever possible to use my inhaler so that my symptoms can be evaluated.
_____ I understand the importance of reporting inhaler use to the School Clinic so that it can be documented.
_____ I understand that it is important for me to let an adult in the School Clinic or Coach, as well as my parents, know if I am having more difficulty than usual with my asthma.
_____ I agree to never share my inhaler with anyone.

Student Signature:_____ Date: _____

School Nurse Signature:_____ Date: _____