

Lakeview School District

2482 Mercer Street
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MS/HS School Nurse – Ext. 237
Elementary School Nurse – Ext 236

ASTHMA INHALERS SELF-ADMINISTRATION BY STUDENT

Student's Name _____ Grade/Homeroom _____
Name of Medication _____ Date Prescribed _____
Diagnosis/Reason _____ Length of Need _____
Dosage _____ Frequency _____
Side Effects/Special Circumstances _____

To self-medicate, the student must be able to: (check all that apply)

- ☐ 1. Respond to and visually recognize his/her name.
- ☐ 2. Identify his/her medication.
- ☐ 3. Demonstrate the proper technique for self-administering his/her medication.
- ☐ 4. Sign his/her medication sheet to acknowledge having taken the medication.
- ☐ 5. Demonstrate a cooperative attitude in all aspects of self-administration.

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria above.

Physician's Signature

Date

Certified School Nurse's Signature

Date

As parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated. The student shall notify the school nurse following each use of an asthma inhaler.

Parent/Guardian's Signature

Date

Student's Signature

Date