Reviewed By:_____ Date:_____

Lake Washington School District #414 Health Services

# INHALER MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

## This section to be completed by HEALTH CARE PROVIDER

***AUTHORIZATION FOR: ☐ SCHOOL YEAR _____ (e.g. 2024-2025)***

| | |
|---|---|
| **Medication**: | **Diagnosis**: ☐ ASTHMA ☐ _____ |
| **Strength**: | **Possible side effects**: |
| **Dose**: _____puffs | |
| **Route**: INHALATION | **Emergency procedure in case of serious side effects and/or severe respiratory distress:**<br>• CALL 911<br>• Other: _____ |
| **When to give medication to student:**<br>☐ PRN for cough, wheezing, chest tightness, or shortness of breath.<br>☐ PRN for exercise, per student and/or parent request.<br>☐ SCHEDULED _____minutes prior to _____.<br>☐ Other: _____ | |

**Minimum time between doses**: ☐Two hours ☐ Four hours ☐Six hours ☐Other_____

**Anticipated action of medication**:

**If approved by School Nurse, can this student self-carry and self-administer medication?**

This student may self-carry this emergency medication at school ☐Yes ☐ No

This student is trained and capable of self-administering this emergency medication. ☐ Yes ☐ No

I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Health Care Provider Signature | Printed Name | Date |
| _____ | (_____)_____ | (_____)_____ |
| Clinic/Office | Phone Number | Fax Number |

## This section to be completed by PARENT/GUARDIAN

- For medication that the student does not self-administer: I authorize the school to administer the above-named medication to my student in accordance with the above order by my student's Health Care Provider.
- I understand and acknowledge it is my responsibility to provide medication in the original container and with an appropriate expiration date, and that it is my responsibility to refill this medication when it is used or expired.
- If my student has permission to self-carry and/or self-administer this medication, my student and I understand the responsibility of self-carrying medication at school and recognize the school will not track regulatory compliance, expiration date, or amount remaining for self-carried medication. On behalf of my student and as their parent/guardian, I agree to hold harmless and indemnify the Lake Washington School District and its officers, employees, and agents against all claims, demands, damages, costs, judgments, or liabilities arising out of or resulting from or caused by self-administration and/or self-carrying of medication by my student.
- I understand and acknowledge (1) that a district RN may not be available to administer the above-named medication and that (2) this order is valid only for the current school year, which includes summer school.

| | |
|---|---|
| _____ | _____ |
| Signature of Parent/Guardian | Date |
| _____ | (_____)_____ |
| Printed Name | Phone Number |