Self-Carry Inhaler

Parent Agreement	Student Agreement
I give permission for my child to carry their Inhaler. My child understands that they must never share their Inhaler with others. I will notify the health services staff of changes in medication or my child's condition. I understand that the school district and its employees will not be held liable for any injury arising from self administration of the medication. I further acknowledge that my child's health care provider must also provide written authorization for the self-administration of this medication and that the school may revoke this permission for any misuse and/or other unsafe practice related to the self-administration of this medication.Note: It is highly recommended to have a back-up of the inhaler that is kept in Health Services.	I agree to: ☐ Follow my prescribing healthcare provider's medication orders. ☐ Use the correct medication administration technique. ☐ Not allow anyone else to use my medication. ☐ Keep a supply of my medication with me in school and on field trips.
Medication:	

Parent Signature:	**Date:**	**Student Signature:**	**Date:**

LSN Assessment: The following information has been reviewed with the above student by the LSN **(office use only)**

☐ Review class schedule/activities which may impact health condition ☐ Acute signs and symptoms of health condition ☐ Medication purpose (preventer or reliever)/dose/frequency/side effects Proper technique for medication administration ☐ Review emergency procedures ☐ Non-medication interventions (if applicable)	☐ Non-medication interventions (if applicable) ☐ Review student agreement ☐ This student has demonstrated the knowledge and skill necessary to properly self-administer the above medication(s).
LSN Signature:	**Date:**

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

- I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
- I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
- If my child has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my child. I will notify Health Services if I prefer to pick up the medication(s) at school.
- I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
- I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
- I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.
- I release school personnel from liability in the event adverse reactions result from taking the medication(s).
- **Transportation: It is the parent's responsibility to notify the transportation company directly of any specific directions for your child's care while riding transportation during the school day**

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature ______________________________ Date ______________

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at any time in writing, and expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: