

BERMUDIAN SPRINGS SCHOOL DISTRICT
York Springs, Pennsylvania 17372-0501

MEDICATION PERMISSION FORM
FOR POSSESSION & SELF-ADMINISTRATION OF ASTHMA INHALERS
Physician's Order

Student Name: _____

Name of Medication: _____

Dosage: _____

Time/Frequency: _____

Diagnosis or Reason for Medication: _____

Possible Side Effect: _____

Recommendations: _____

Emergency Response Procedures: _____

Estimated Termination Date: _____

(All authorizations expire at the end of the school year and must be renewed on an annual basis.)

Both boxes below must be checked by the physician for the student to carry and self-administer the inhaler. If both boxes are not checked, the inhaler will be kept in the nurse's office:

☐ Student is knowledgeable about this medication and how to administer it and understands not to share the inhaler with another person.

☐ Student is qualified to self-administer medications as prescribed by his/her physician and may carry his/her inhaler with them while on school property and at school-sponsored events or activities.

Physician's Signature _____ **Date** _____

Address _____ **Phone Number:** _____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication or its administration when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken or administered properly. I am aware that any improper use/sharing of the above named medication by the student to whom it is prescribed or failure to comply with the District's policy will result in the immediate confiscation of the inhaler, loss of privilege to self-administer, and possible disciplinary consequences.

- My child may self-administer the above medication as prescribed by his/her physician.
- My child will report to the school nurse or designated personnel immediately following each use of the inhaler. The nurse may assess and monitor student use to assure that safe practices are being followed.

Parent's/Guardian's Signature _____ **Date** _____

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician and the school nurse, as well as the district's medication policy. I agree to notify the school nurse immediately following each use of my asthma inhaler. I agree that my asthma inhaler is for my use only and may not be shared with others. I am aware that any abuse of the privilege will result in the confiscation of my inhaler and/or other disciplinary consequences.

Student's Signature _____ **Date** _____