OWEN J. ROBERTS SCHOOL DISTRICT

SECTION: PUPILS

TITLE: POSSESSION/USE OF ASTHMA INHALERS

ADOPTED: 6/27/05

REVISED: 10/12/15

REVIEWED: 1/14/13

ASTHMA INHALERS – SELF-ADMINISTRATION BY STUDENTS

_____ _____ _____
Student's Name Grade Date

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 of medication.

_____ _____ _____
Name of Medication Dosage Frequency

This student is capable of self-administering the prescribed asthma medication.

_____ _____
Date Signature (Prescribing Physician)

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

_____ _____
Date Signature (Certified School Nurse)

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 when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school

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bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

_____ _____

Date Parent/Guardian Signature

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler.

_____ _____

Date Student's Signature