Medication Agreement for Asthma Treatment

Please return to:________________________________ **Fax:**__________________
School

Name:____________________________________ **DOB**______________ **ID#**____________

Medication________________________________	Medication________________________________
Dose____________________ Route__________	Dose______________________ Route________
Time/Frequency____________________________	Time/Frequency____________________________
Medication used for_________________________	Medication used for_________________________
Side Effects_______________________________	Side Effects_______________________________

Printed Name of Prescribing Practitioner____

- ☐ This order is effective for the period from ________________________ to __________________
  Month / Day / Year   Month / Day / Year
- ☐ The student has been instructed by me or a member of my staff when & how to use his/her inhaler.
- ☐ This student is capable of self-administration of asthma treatment.
- ☐ This student **is not able** to self administer asthma treatment.

Prescribing Practitioner Signature____________________________________**Date**________

It is agreed and understood that this medication will be provided by the parent/guardian and may be administered by the student when necessary, to treat the identified symptoms or condition.

If the parent/guardian chooses to have the medication kept locked in the health office and dispensed by the school nurse or trained school designee as per the orders noted above, they release and hold harmless PSD, the school nurse or trained school designee of any claim, demand or action associated with the administration or failure to administer the medication.

Parent:

- ☐ By checking this box: I request my child's asthma inhaler(s) be kept and administered in the school health office.
- ☐ By checking this box:
  1. I agree to see that my child carries the inhaler(s) that is(are) prescribed.
  2. It has been recommended that back up asthma medication be provided to the school health office for emergencies.
  3. I will agree to notify the school if there are any changes to the treatment plan.
- ☐ By checking this box: I give permission for the school staff to contact the prescribing health care provider regarding this medication and/or health condition.

Parent / Guardian signature____**Date**____________

Contract for Students Carrying Asthma Inhalers While at School

Name: ____________________________ DOB: _______________ ID: ____________

STUDENT

□ I plan to keep my asthma inhaler(s) with me at school rather than in the school health office.

□ I agree to use my asthma inhaler in a responsible manner, according to my physician's orders.

□ I will not allow any other student to use my asthma inhaler(s).

□ I will notify the school health office if the treatment is not helping my asthma.

Student Signature____**Date**_______________

SCHOOL NURSE

□ The above student has demonstrated correct technique for using the asthma inhaler and an understanding of the physician order for its use.

□ School staff that have the need to know about the student's condition and the need to carry medication has been notified.

□ The above student, to the best of my knowledge, is capable of self administering the asthma inhaler per the health care action plan.

□ I do not feel the above student is capable of self-administration and the parent has been notified.

Nurse Signature____**Date**_________________