Student Name: _____Date of Birth: _____
School: _____ Grade: _____ Year: _____

SELF-ADMINISTRATION OF ASTHMA MEDCATION

Student Agreement:

- I will use correct inhaler technique (demonstrate to nurse)
- Not allow anyone else to use my medication
- Keep a current supply of my medication at school in_____(location)
- Notify the school nurse if
  - ___I need to take my quick-relief medication more than 2x/week
  - ___My symptoms don't go away after taking my medication
  - ___I suspect I am having side effects from the medication
  - ___I have asthma symptoms after completing physical activity
  - ___I do not understand any aspect of my medication
- Follow my health care providers orders
- Refill my prescription before it runs out and bring it to school

Student Signature: _____ Date: _____
School Nurse Signature: _____Date: _____

TO BE COMPLETED BY PHYSICIAN

It is my professional opinion that the above student is capable of carrying and self-administering *the following medication for treatment of asthma:*

Medication	**Route**	**Dose**	**Frequency**
Medication	**Route**	**Dose**	**Frequency**

_____ _____
Signature of Medical Care Provider **Phone/ Fax**

_____ _____
Printed Name of Medical Care Provider **Medical Provider Phone Number and Clinic Name**

I hereby give permission for my child to self-administer medication. I give my medical provider and Farmington Health Services permission to release and obtain information from each other as necessary. This authorization takes effect the day I sign it. It expires one year from the date of my signature. I understand that I may change this authorization at anytime.

_____ _____
Signature of Parent/Guardian Date