SELF-ADMINISTRATION OF ASTHMA MEDICATION AUTHORIZATION

Hastings Schools
Independent School District 200
OFFICE OF SPECIAL SERVICES
1000 W. 11th Street
Hastings, Minnesota 55033

Student _____

DOB ___/___/_____ School _____

Grade _____ School Year: 20___ / 20___

☐Student has 504 Plan ☐Student has IEP

When a prescribing health professional, parent/ guardian, student and school nurse agree that self-administration of medications is appropriate for an individual student, the procedure must be done safely, carefully and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school. The medication must be brought to school in a container appropriately labeled by a pharmacist or the prescribing health professional. A written health care plan for the student must be developed by the school nurse. A student who has demonstrated competencies noted on his/her Individual Health Plan may then be allowed to self-administer medication if he/she signs the agreement on the back of this form.

This form must be completed by the prescribing health professional and parent/guardian and returned to the school nurse. Orders must be renewed annually or whenever medication, dosage or administration changes.

Building Nurse: _____

LSN: _____

Phone: _____

FAX: _____

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I believe that (student's name)

Is capable of self-administering the following medications:

✔ **Check all that apply:**

I recommend self-administration of this **RELIEVER** medication at school.

_____

Medication Route Dose Frequency

I recommend self-administration of this **PREVENTATIVE** medication at school.

_____

Medication Route Dose Frequency

Continue for school year: Yes___ / No___ Discontinue on: (Date) _____

COMMENTS: _____

_____ _____

SIGNATURE of Prescribing Health Professional CLINIC

_____ _____ _____

PRINT Name Phone Date

I hereby give permission for my child to self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health professional.

_____ _____

Signature of Parent/Guardian **Date**

School Health Assessment
ASTHMA MEDICATION SELF-ADMINISTRATION CHECKLIST

20___/20___

Student name: _____ Grade: _____

1. To be used for the **RELIEF of:** _____

_____

Medication Route Dose Frequency

2. To be used for the **PREVENTION of:** _____

_____

Medication Route Dose Frequency

NURSING ASSESSMENT TO BE COMPLETED BY DISTRICT 200 NURSE

The following information will be reviewed with students who intend to carry asthma medication with them for use during the school day:

- Asthma triggers
- Review class schedule/activities which may impact asthma
- Knowledge of early warning signs
- Acute signs and symptoms
- Medication purpose (preventer or reliever)/dose/frequency/side effects
- Proper technique for medication administration
- Proper technique with spacer or holding chamber if prescribed
- Review asthma action plan
- Review use of peak flow meter
- Review of emergency care plan
- Non-medication interventions
- Explain student agreement at time of nursing assessment

This student has demonstrated the knowledge and skill necessary to properly administer the above medication for treatment of asthma.

Signed: _____ Date: _____
Registered Nurse

SELF MEDICATING AUTHORIZATION RECEIVED: Physician ☐ Parent ☐

STUDENT AGREEMENT

I agree to:

- Follow my health professional's prescribing orders for correct medication/dose and frequency
- Use the correct technique for administration of medication
- NOT allow anyone else to use my medication
- Keep a current supply of my medication at school
- Notify the school health staff, health assistant or nurse, if my symptoms continue or worsen or if I suspect I am experiencing side effects from my medication

If health status changes or student agreement is not followed, a reassessment will occur.

Signed:_____ Date: _____
Student signature