

CROMWELL PUBLIC SCHOOLS

AUTHORIZATION FOR THE SELF-ADMINISTRATION OF INHALED ASTHMA MEDICATION

Physician's/Dentist's/Advanced Practice Registered Nurse's/Physician Assistant's Orders

Name of Student: _____ Date: _____

Address: _____ DOB: _____

Condition for which drug is being prescribed: _____

Name of Drug (including generic name): _____

Dose: _____ Frequency: _____

Relevant side effects and management: _____

Medication shall be administered from _____ (date) to _____ (date)

Self- Administration:

1. I have conferred with this child's parents/guardians and feel this medication may be self-administered.
2. This student has been appropriately instructed regarding self-medication.

Physician's/Dentist's/APRN's/PA's Name: _____ Telephone #: _____

Address: _____

Physician's/Dentist's/APRN's/PA's Signature: _____ Date: _____

PERMISSION OF PARENT/GUARDIAN FOR SELF-ADMINISTRATION FOR SELF-ADMINISTRATION OF MEDICATION

- I hereby request that the above medication, ordered by the physician/dentist/APRN/PA of my child, _____, be administered by my child. I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician/dentist/APRN/PA.
- I understand that I must supply the nurse with back-up medication in the event the medication is lost or misplaced by my child.
- I understand this medication will be destroyed if it is not picked up on the last day of school.
- I give permission for the exchange of information between the prescriber and the School Nurse necessary to ensure the safe administration of such medication.

Name: _____ Date: _____

Signature: _____ Emergency Telephone #: _____

STUDENT AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

I understand that I may use my asthma inhaler as prescribed by my doctor. I will not use it in any other way. I will not let any other person use my inhaler. I will go to the school nurse if I do not feel well or the medication does not give me relief after the number of sprays allowed by my doctor. I understand that if I do not follow these rules, I will not be allowed to self-medicate.

Signature of Student: _____ Date: _____