NORTHWEST AREA SCHOOL DISTRICT

School Health Services

SELF ADMINISTRATION BY STUDENTS: ASTHMA INHALERS/EPINEPHRINE AUTO-INJECTORS

______________________________________ __________ ___________________

Student's Name Grade Date

Medication____

To self-carry and self-administer medication, the student must be able to:

__________1. Respond to and visually recognize his/her name.
__________2. Identify and understand the actions of his/her medication.
__________3. Measure and independently administer the medication using the proper technique.
__________4. Demonstrate maturity and reliability in safely administering and carrying medication.
__________5. Assure that his/her medication will ***not*** be made available to other students.
__________6. Demonstrate a cooperative and responsible attitude in all aspects of self-administration of medication.
__________7. Assure the school nurse he/she will notify the teacher and nurse immediately following each use and self-administration of the prescribed medication. Medication self-administration documentation records will be maintained in the nurse's office.
__________8. Demonstrate skill of medication administration (use of epipen trainer, all steps for inhaler administration except for actual inhaler medication administration)
__________9. Epinephrine only—review Epipen administration video in nurse's office

The above named student has demonstrated the ability to self-administer the physician prescribed asthma medication and/or epinephrine auto-injector, as indicated by the criteria listed above. The school has the right to deny this privilege or restrict use, if school policies are abused or ignored.

_______________ ____

Date Signature (Building Nurse/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 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 medication 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 medication and follow the directions for its use per 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 medication.

_______________ ______________________________________

Date Student's Signature

Copy provided to Parent/Guardian by: Nurse_____________________________ Date___________

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