ASTHMA MEDICATION
SELF-ADMINISTRATION FORM

_____ _____
Name of Student Grade/Teacher

_____ _____
Name of Physician Physician's Phone Number

_____
Name of Medication Dosage Time
_____

_____

Medication must be dispensed according to Springfield Public Schools Medication Policy.
The inhaler must be labeled with student's name.

RESPONSIBILITIES FOR CARRYING RESPIRATORY INHALERS

OBSERVED
YES NO

____ ____ Asthma Action Plan returned
____ ____ Demonstrates correct use of inhaler
____ ____ Describes proper timing for inhaler use
____ ____ Understands not sharing inhaler with other students
____ ____ Will keep inhaler on person
____ ____ Agrees to come directly to the Health Office if having difficulty with breathing, wheezing, or is experiencing chest tightness after using the inhaler
____ ____ Will provide a second inhaler to be kept in the Health Office

THE STUDENT ***DOES / DOES NOT*** DEMONSTRATE MEETING THE ABOVE SPECIFIED RESPONSIBILITIES.

THE PRIVILEGE OF CARRYING THE INHALER ***WILL / WILL NOT*** BE ALLOWED.

_____ _____
Student Signature Date RN Signature Date

COMMENTS: _____

_____

MY CHILD WILL BE RESPONSIBLE FOR CARRYING THIS RESPIRATORY INHALER AND WILL SELF-ADMINISTER. MY CHILD AGREES TO FOLLOW THE DISTRICT'S PROCEDURES CONCERNING THE HANDLING AND ADMINISTRATION OF THIS MEDICATION.

_____
Parent/Guardian Signature Date

8/12