ELLWOOD CITY AREA SCHOOL DISTRICT

Self-administration of Asthma Medication via Inhaler at school

Student Name _____ Grade/Class_____

Diagnosis_____

Inhaler Medication_____ Dosage _____puffs(s)

Frequency (please state MINIMUM prn spacing)_____

Side Effects_____

Other prescribed medications _____

THIS STUDENT IS QUALIFIED AND RESPONSIBLE TO CARRY AND SELF-ADMINISTER ASTHMA MEDICATION VIA INHALER AT SCHOOL

( ) YES ( ) NO

_____

Physician Signature (print) Date

PARENT STATEMENT

As parent (guardian) of this student,

1. I request that the ECASD comply with the physician's recommendation to allow my child to carry and self-administer his/her own asthma medication via inhaler as ordered.
2. I affirm that my child is qualified to correctly use the inhaler and will be responsible to ensure that it is not available to other students. My child will also be responsible for notifying the school nurse immediately when his/her condition requires the use of the inhaler. I understand that any misuse will result in loss of self-administration privilege.
3. I relieve the school district and its employees of any responsibility for ensuring that the medication is taken and for the benefits and/or consequences of taking or omitting the medication.

_____

Parent Signature (phone #) Date