

Union Pointe Academy

SELF-MEDICATION FOR ASTHMA INHALER



School policy requires consent of parent/legal guardian and a physician order, in writing, for a student to self-administer asthma medication. The following information is necessary in order to comply with this policy.

ALL ITEMS MUST BE COMPLETED IN FULL. Please return the completed form to the school office.

THIS SECTION IS TO BE COMPLETED BY THE PARENT OR GUARDIAN		
_____	_____	_____
Student	Date of Birth	Grade

Address		

Telephone –Home	Telephone – Work	Telephone - Other
I give my permission for school personnel designated to administer the medication to my child as prescribed above, and further agree to the following:		
<ol style="list-style-type: none"> 1. Submit to school personnel a revised written statement signed by the licensed prescriber if the medication, dosage, schedule is changed or eliminated. 2. Grant permission for the school to confer with the licensed prescriber regarding my child’s health and treatment issues as they pertain to the this medication/procedure/diagnosis and his/her behavioral management needs. 3. Cooperate with school personnel in assisting my child to comply with medication instructions. 4. Release Union Pointe Academy and their designated personnel from any liability concerning the administration or non-administration of the prescribed medication to the student. 5. Submit to school personnel any change in telephone numbers or emergency contacts. 		
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

➤ The inhaler itself must be labeled. The pharmacist’s label must show the student’s name, licensed prescriber name, date, pharmacy name and telephone, name of medication, prescribed dosage and frequency, special handling and storage directions.

THIS SECTION IS TO BE COMPLETED BY THE LICENSED PRESCRIBER			
_____	_____	_____	_____
Diagnosis	Medication	Dosage	Frequency
_____	_____		
Date to Begin	Date to End		
Possible Side Effects: _____			
Adverse Reactions to be reported to Licensed Prescriber: _____			
Side Effects or possible severe reactions for unauthorized user: _____			
Procedure to follow in the event that medication does not produce the expected relief from student’s asthma attack: _____			

Other special instructions: _____			

_____	_____	_____	
Licensed Prescriber Name	Licensed Prescriber Signature	Date	

Address	Licensed Prescriber Phone Number	Fax Number	

A NEW REQUEST FORM MUST BE SUBMITTED EACH SCHOOL YEAR OR FOR EACH NEW MEDICATION.

FOR SCHOOL USE ONLY

The following student has demonstrated correct use of the inhaler and understanding of when to use the inhaler and the correct dosage and frequency. The student also has been instructed to inform the clinic when having used the inhaler.

Student Signature _____ Date _____

Parent Signature _____ Date _____

ALL ADMINISTRATIONS MUST BE REPORTED TO THE OFFICE, SO PARENTS CAN BE NOTIFIED.