



### Self-Administration of Asthma Inhaler Student Agreement

Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Inhaled Medication: \_\_\_\_\_

Date: \_\_\_\_\_

I agree to:

- Follow my prescribing health professional's medication order.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep the medication with me in school and on field trips.
- Inform the school nurse of the time and reason for taking the inhaler.
- Notify (or have someone else notify) the school nurse immediately if the following occurs:
  - My symptoms continue to get worse after taking the medication.
  - My symptoms reoccur within 2-3 hours after taking the medication.
  - I think I might be experiencing side effects from my medication.
  - Other \_\_\_\_\_
- I understand that permission for self-administration of medication may be discontinued if am unable to follow the safeguards established above.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian/Relative Caregiver

\_\_\_\_\_  
Date

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- Student verbalizes dose \_\_\_\_\_
  - Student demonstrates proper technique
    - Removes cap and shake if applicable
    - Attaches spacer if applicable
    - Breathes out slowly
    - Presses down inhaler to release medication
    - Breathes in slowly
    - Holds breath for 10 seconds
    - Repeats as directed
  - Student verbalizes safe use
  - Student verbalizes symptoms/signs of when medication is needed & when to notify school nurse
  - Parent permission to self-administer

The student has demonstrated knowledge about the proper use of his/her medication and necessary permissions (parent and licensed healthcare provider) are on file.

\_\_\_\_\_  
Signature of School Nurse

\_\_\_\_\_  
Date