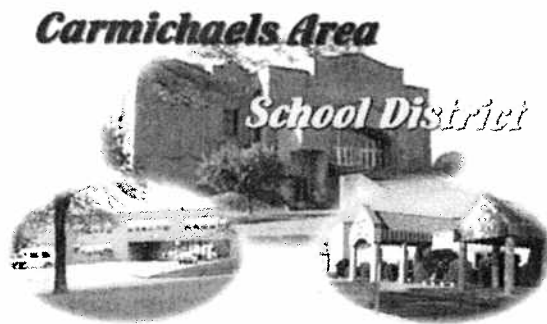


**ASTHMA INHALERS  
SELF ADMINISTRATION  
BY STUDENTS**



\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Date

To self medicate, the student must be able to: (check all that apply)

- \_\_\_\_\_ 1. Respond to and visually recognize his/her name
- \_\_\_\_\_ 2. Identify his/her medication
- \_\_\_\_\_ 3. Demonstrate the proper technique for self-administering his/her medication
- \_\_\_\_\_ 4. Sign his/her medication sheet to acknowledge having taken the medication
- \_\_\_\_\_ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Date

\_\_\_\_\_  
Frequency

The above named student has demonstrated the ability to self-administer the physician prescribed asthma medication, as indicated by the criteria listed above.

\_\_\_\_\_  
Date

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

As the parent/guardian of above named student, I relieve the Carmichaels Area 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 inhaler 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 asthma inhaler and to follow the directions for its use as ordered by 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 inhaler.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Signature