* *Student to fill out the top part of this form only if student will be self administrating inhaler*
* *The* ***Nurse at the Dr. Clinic*** *should complete the bottom part of this page.*

**Name: Grade:**

 **Name of Inhaler:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_**

 **The Studentwill agree to the following below:**

***I agree to:***

* Follow my prescribing health professional's medication orders.
* Use correct medication administration technique.
* Make note of when I use medication at school.
* Not allow anyone else to use my medication under any circumstances.
* Keep supply of my medication with me in school and on field trips.
* Notify the school nurse or school health paraprofessional if the following occurs:
	+ My symptoms continue or get worse after taking 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 I am unable to follow the safeguards established above.

**Signature of Student Date**

**THE NURSE AT THE DR. CLINIC SHOULD COMPLETE THE BELOW:**

 □ Verbalize Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Verbalizes Asthma Episode Symptoms

□ Demonstrates Proper Technique

* removes cap and shake if applicable
* attaches spacer if applicable
* breathes out slowly
* presses down inhaler to release medication
* breathe in slowly
* holds breath for 10 seconds
* repeats as directed.

□ Verbalizes Safe Use of Inhaler: The student has demonstrated knowledge about and proper use of his/her inhaler.

**Signature of Nurse** **Date**