Providence Academy Health Office • Student Agreement
Self-Administration of Inhaler Medication

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or health office personnel if the following occurs:
  - υ My symptoms continue or get worse after taking the medication
  - υ My symptoms reoccur within 2-3 hours after taking the medication
  - υ I suspect that I am experiencing side effects from my medication
  - υ Other_____

I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above. All electronic signatures indicate approval.

_____ _____
Signature of Student **Date**

_____
Print Name of Student

The student has demonstrated knowledge about and proper use of his/her inhaler.

_____ _____
Signature of Licensed School Nurse **Date**

I have read the above student agreement.

_____ _____
Signature of Parent/Guardian **Date**

Attach completed Medication Authorization Form