



## Health Office • Student Agreement Self-Administration of Inhaler Medication

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**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:
  - ∪ My symptoms continue or get worse after taking the medication
  - ∪ My symptoms reoccur within 2-3 hours after taking the medication
  - ∪ I suspect that I am experiencing side effects from my medication
  - ∪ 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**