

**ASTHMA MEDICATION SELF-ADMINISTRATION FORM**

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

*The Missouri Safe Schools Act of 1996 provides for students to carry and self-administer life-saving medications when the following criteria are met:*

- 1) *Written authorization by the parent/guardian*
- 2) *Medical history of students asthma on file at the school*
- 3) *Written asthma action plan/individual healthcare plan on file at school*
- 4) *Written authorization from the prescribing physician that child has asthma or is at risk of having anaphylaxis, has been trained in the use of the medication and is capable of self-administration of the medication.*

**THIS MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR**

**MEDICATION NAME** \_\_\_\_\_ **Dose** \_\_\_\_\_ **Time or Interval** \_\_\_\_\_  
**Route/Inhalation device** \_\_\_\_\_ **Instructions** \_\_\_\_\_

**Important Note:** May repeat use of short-acting bronchodilator dose 2-6 puffs (i.e. Albuterol) with a spacer/spacer with mask every 20 minutes for 2 treatments if asthma symptoms are not improving (Expert Panel Report-EPR3, 2007 National Asthma Guidelines). Notify school staff if one dose fails to relieve symptoms.

**MEDICATION NAME** \_\_\_\_\_ **Dose** \_\_\_\_\_ **Time or Interval** \_\_\_\_\_  
**Route/Inhalation device** \_\_\_\_\_ **Instructions** \_\_\_\_\_

**If epinephrine, notify staff immediately when used. May repeat dose of epinephrine in 10-15 minutes if symptoms are not resolving.**

**ALLERGIES: list known allergies to medications, foods, or air-borne substances** \_\_\_\_\_

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff if one dose fails to relieve asthma symptoms in 20 minutes or does not sustain my child for 3 or more hours. My child understands to notify school staff immediately if epinephrine is used so 911 can be called. I acknowledge that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my child or the administration of such medication by school staff.

**Signature of parent or legal guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian:**

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

**Emergency Contact:**

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

I, a licensed health care provider, certify that this child has a medical history of asthma and/or anaphylaxis, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if one dose of the medication fails to relieve asthma symptoms in 20 minutes or sustain the child for at least 3 hours. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

**Health Care Provider:**

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

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

RN Review: \_\_\_\_\_ SIS: \_\_\_\_\_  
 Notifications: teacher bus driver office  
 Notes on reverse side