Lincoln Christian School

Inhaled Asthma Medication Administration Form

Student's Name _____ DOB _____ Grade/Teacher _____

Self-Carry & Self-Administration Guidelines

- No student will be permitted to self-carry and/or self-administer without the express written consent of the student's parent/legal guardian and the student's physician.
- Only those inhaled asthma medications that are considered to be life-sustaining may be carried by students if ordered by a physician.
- Controlled substances may not be self-carried or self-administered by a student under any circumstance. Controlled substances must be administered by designated school personnel.
- No experimental or investigational drugs without proper FDA approval or expired medication will be self-administered at school.
- Student-carried inhaled asthma medications must meet the labeling requirements as noted in the Student Handbook.
- A completed "Inhaled Asthma Medication Administration" form must be on file and kept up-to-date in the designated Health Room for any inhaled asthma medication carried by a student or kept with the RN. A new form is required each school year, and anytime a change of dosage amount, time, etc., occurs.
- It is the responsibility of the prescribing physician and the parent/legal guardian to educate the student regarding all aspects of self-carry and self-administration of inhaled asthma medications.
- Inhaled asthma medications may not be self-administered in any manner other than as specified on the label without written instructions from a licensed physician.
- The school, its employees, agents, and representatives shall incur no liability as a result of any injury or issue arising from the self-administration of medication by any student.
- Any student who carries an approved inhaled asthma medication is responsible for safeguarding that medication at all times. The school is not responsible for monitoring administration, effects, custody, disposal, or any other aspect of student-carried medications. The school is not responsible for lost or stolen medications.
- Permission to carry inhaled asthma medication may be withdrawn for failure to comply with any aspect of this policy.

Self-Carry & Self-Administration Guidelines in the Absence of a RN

- When ordered by a physician and requested by a parent/guardian, students will be allowed to access inhaled asthma medications from non-nurse employees or representatives for the purpose of self-administration.
- Non-nurse employees or representatives of LCS will not be responsible for assessment or determination of the student's condition prior to, during, or after self-administration of an inhaled asthma medication.
- The student may do peak flow readings if requested by the parent/guardian or physician. The parent must provide the supplies required for the student to perform peak flow readings.
- A parent/guardian will be notified when a student self-administers due to the unavailability of a RN.

To Be Completed by Student

By my signature following, I acknowledge that I have read and understand the Inhaled Asthma Medication Administration guidelines, and I agree to abide by the guidelines at all times.

Student's Signature: _____ Date: _____

Please Note: This form is not valid unless completed by a parent/legal guardian and attending physician on page 2.

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Inhaled Asthma Medication Administration (cont.)

To Be Completed by Parent/Legal Guardian

I, _____ the parent or legal guardian of _____("Student") acknowledge that I have read and understand the Inhaled Asthma Medication Administration guidelines, and I agree to abide by the guidelines at all times. I understand that LCS and its employees, agents, and representatives, shall incur no liability as a result of any injury or issue arising from the self-administration of medication by my student. Furthermore:

Please check <u>one</u> of the following options:

- ☐ I request that my student be allowed to self-carry and self-administer the physician-ordered inhaled asthma medication listed below. I understand that my student and I are responsible for safeguarding the carried medications at all times. I understand that it is recommended that I provide the school with any additional supply of the medication ordered below as a back-up, and I assume all liabilities if I choose not to provide an additional supply to the school. I give my student permission to resume activities without being assessed by a nurse.

- ☐ I request that the school nurse administer the physician-ordered inhaled asthma medication listed below. In the absence of the school nurse, an employee or representative designated by the school will provide the medication for my student to self-administer and assist if needed. I understand that I will be notified if my student self-administers this medication. In the absence of a school nurse (select one):
  - ☐ My student is capable of deciding if he/she is able to resume school activities. If my student states that he/she is unable to resume activities, call one of my emergency contacts to pick up my child.
  - ☐ Notify one of my emergency contacts to pick up my student.
  - ☐ Other (specify) _____

Parent/Guardian's Signature: _____ Date: _____

To Be Completed by Physician

Student's Name: _____ Diagnosis: _____

Medication Order (note the interval for repetition of the dose if p.r.n.): _____

_____

Side Effects to Expect: _____

Please check <u>one</u> of the following options:

- ☐ In my professional opinion, it is medically necessary that this student be allowed to <u>self-carry and self-administer</u> the above medication. I verify this student has the knowledge and ability to safely administer and safeguard this medication, and the student can assess whether or not they are able resume activities without being assessed by a nurse.

- ☐ I authorize this medication to be administered by a RN. In the event that a nurse is not available, I authorize this student to self-administer the above medication and receive assistance from a designated school representative, if needed. I verify that this student has the knowledge and ability to safely administer this medication.

Review guidelines on page 1 before signing:

Physician's Name: _____ Phone Number: _____

Physician's Signature: _____ Date: _____