THIS FORM MUST BE UPDATED ANNUALLY

Authorization for Self-Administration of Asthma Medication **2021-22**

River Grove: A Marine Area Community School
PO Box 178 | 14189 Ostlund Trail North | Marine on St Croix, MN 55047
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Student_____ Birth date:_____School Year:_____ Grade: _____

	Medication	Strength	Dose	Time	Route	Possible Side Effects
1						
2						
3						

Other considerations/directions: _____

Start Date: _____ Stop Date: _____
(All authorizations expire at the end of the school year.)

☐ Student is knowledgeable about the medication and how to administer it.
☐ Student has the skills to safely possess and use an inhaler, and may self-administer the medication.

_____ _____ _____
Print or type name of Licensed Prescriber | Clinic name | Physician's / Licensed Prescriber's signature

_____ _____ _____
Clinic Phone number | Clinic Fax number | Date

Parent/Guardian Authorization

1. I/we request our child to be able to carry and take their own asthma medication and/or inhalers at school as prescribed above. I/we release the school personnel from liability in the event adverse reactions result from taking the medication(s) by our child outside of the health room. I/we will also provide a supplement bottle of medication or inhaler for the health room to store in case of loss of the medication at school.
2. I/we will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.) My/our child will sign and follow the agreement with the Licensed School Nurse on the back of this form.
3. I/we give permission for the school nurse to consult with the above named student's licensed prescriber regarding any questions that arise with the listed medication(s) or medical condition(s) being treated. My child may self-administer their inhaler/medication as needed.

_____ _____ _____
Parent/Guardian Signature | Relationship to Student | Date

Minnesota Statutes 121A.22:
Medication must be supplied in the original prescription bottle or inhaler with student's name on it.

Student Agreement

I agree to:

1. Follow my prescribing health professional's medication orders.
2. Use correct medication administration technique.
3. Maintain a written record of my medication administration at school.
4. Not allow anyone else to use my medication.
5. Keep a supply of my medication with me in school and on field trips.
6. Notify the school health office personnel if any of the following occurs:
    a. My symptoms continue or get worse after taking the medication.
    b. My symptoms reoccur within 2-3 hours after taking the medication
    c. I suspect that I am experiencing side effects from my medication
    d. Other _____
7. I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

_____ _____

Signature of Student Date

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

_____ _____

Signature of Licensed School Nurse or RN Date