Authorization to Self Carry and Administer Medication at School

Epi Pens and Inhalers Only

Brentwood Borough School District

Student Name _____ Grade _____ Date _____

To self medicate, the student must be able to (check all that apply):

- ☐ 1. Respond to and visually recognize his/her name.
- ☐ 2. Identify his/her medication.
- ☐ 3. Demonstrate the proper technique for self-administering his/her medication.
- ☐ 4. Sign his/her medication sheet to acknowledge having taken the medication.
- ☐ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of Medication _____ Dosage _____ Frequency _____

The above-named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

Date _____ Signature (Certified School Nurse) _____

As the parent/guardian of the above-named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above-listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above-named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

Date _____ Parent/Guardian Signature _____

Printed Name: _____

Address: _____

Contact Phone: _____

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler.

Date _____ Student's Signature _____

Asthma Action Plan / Medication Administration Form

Brentwood Borough School District

Student Name: _____ Birth Date: _____

School: _____ Grade: _____ Room: _____

EMERGENCY INFORMATION

Parent/ Guardian Names: _____

Mother Phone (H): _____ Father Phone (H): _____

Mother Phone (C): _____ Father Phone (C): _____

Parent/ Guardian signature: _____ Date: _____

ASTHMA EMERGENCY ACTION:

The following are possible signs of an asthma emergency;

IF ANY OF THESE SIGNS ARE PRESENT, NOTIFY THE NURSE IN YOUR BUILDING IMMEDIATELY!

- Difficulty breathing, when walking or talking
- Blue or grey discoloration of the lips or fingernails
- Failure of medication to improve symptoms

Licensed Prescriber Medication Order

Name of Medication: _____ Date: _____

Route and Dosage: _____

Time of Administration: _____ Discontinuation Date: _____

Triggers: _____

Steps to be taken for an Acute Asthma Episode: _____

_____

Licensed Prescriber Name printed: _____ Phone _____

Licensed Prescriber Signature: _____ Date: _____

PARENTS/ GUARDIANS: In accordance with school policy, all medications must be in an original prescription bottle/ container from a pharmacy. By signing this form you give permission for medication to be administered during the school day by school health personnel. This form replaces the previous medication form used for inhalers, and much be renewed each year.