Edgerton District #581 Schools

Health Related Services – 507-442-7881

Self-Administration of Inhaler Medication Student Agreement

Name _____ Grade _____

Inhaled Medication _____ Date _____

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique
- Make a note of when I use medication at school.
- Not allow anyone else to use my medication under any circumstances.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or school employee if the follow occurs:
    - My symptoms continue to get worse after taking the medication
    - My symptoms reoccur within 2-3 hours after taking the medication
    - I think I might be experiencing side effects from my medication.
    - Other : _____
- I understand that permission for self-administration of medication may be discontinued if I am unable to follow the safeguards established above.

_____ _____

Signature of Student Date

- Verbalizes Dose _____

- Verbalizes Asthma Episode Symptoms

- Demonstrates Proper Technique

  - Removes cap and shakes if applicable
  - Attaches spacer if applicable
  - Breathes out slowly
  - Presses down inhaler to release medication
  - Breathes in slowly
  - Hold breath for 10 seconds
  - Repeat as directed.

- Verbalizes safe use of inhaler

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

_____ _____

Signature of School Nurse Date

*Keep copy of this on file in health office.