CLOVIS MUNICIPAL SCHOOLS **GEN 650**

ASTHMA INHALER SELF-CARRY AUTHORIZATION FORM

NMAC 6.12.2.9

This order is valid only for school year (current) _____ including summer session, unless revoked by the parent, physician, or school nurse or if the student fails to comply.

School: _____ Grade: _____

This form must be completed fully in order for a student to self-carry and administer his/her prescribed asthma inhaler while at school, school-sponsored activities, or in transit to and from school or school-sponsored activities.

The following requirements must be met in order for your child to carry his/her inhaler at school:

- Section 1 must be completed by the prescribing provider.
- Section 2 must be completed and signed by a parent or guardian.
- Section 3 must be completed by the student and verified by the School Nurse.
- The student must comply with all instructions and regulations associated with carrying and administering the inhaler.
- Prescription medication must be in an original container labeled by the pharmacist or prescriber.

Section 1 – Prescriber Authorization

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of Administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ❑ None expected ❑ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Please initial next to each statement:

_____ I confirm that this student has been fully instructed on the use of his/her medication including dose, frequency, technique, and side effects.

_____ This student has demonstrated the proper use of his/her inhaler in my office.

_____ I confirm that this student is capable of self-administering the prescribed medication **OR**

_____ I **DO NOT** recommend that this student be allowed to self-carry and administer the prescribed medication.

Prescriber Name/Title: _____ Telephone: _____

Fax: _____ Address:_____

Prescriber Signature: _____ Date: _____

✷ **Parents/Students please complete the other side of this form.** **(8/2006)**

Section 2 – Parent/Guardian Authorization

Please initial next to each statement:

_____ My child has demonstrated proper use of his/her inhaler in my presence.
_____ My child understands his/her asthma triggers, symptoms, and treatment plan.
_____ My child understands the importance of letting school staff and parents know when he/she is having more difficulty than usual with asthma symptoms or episodes.
_____ My child understands that he/she is to keep inhaler with him/her at all times.
_____ My child understands that he/she should never share his/her inhaler with another student.
_____ I agree to provide the school office with an extra (back-up) rescue inhaler.
_____ I acknowledge that it may not be possible for the school staff to monitor or document doses, frequency, technique, or response of my child to the self-carried medication.
_____ I agree to provide a new authorization form if there is any change in the medication, dosage, administration time, or special instructions regarding the medication.
_____ I understand that the School Nurse will share information relevant to the prescribed medication as he/she determines appropriate for my child's health and safety.

I/We, the parents/guardians of _____ (Student Name), **give/do not give (circle one)** permission for him/her to self-carry and administer inhaled asthma medication.

As this inhaler is a parent-authorized and physician-prescribed medication, I/We, the parents/guardians of _____ (Student Name), relieve the Clovis Municipal School District or any employee of any responsibility for the benefits or consequences of this medication. I also acknowledge that the Clovis Municipal School District bears no responsibility for ensuring that this medication is taken.

Parent/Guardian Signature: _____ Date: _____

Section 3 – Student/School Nurse Certification

Please initial next to each statement:

_____ I agree to use my inhaler as prescribed above. I understand my asthma triggers, symptoms, and treatment plan (verbalize to School Nurse).
_____ I understand the correct technique for administering my inhaler (demonstrate to School Nurse).
_____ I agree to keep my inhaler with me at school at all times, as well as a back-up inhaler in the office.
_____ I agree to go to the office whenever possible to use my inhaler so that my symptoms can be evaluated.
_____ I understand the importance of reporting inhaler use to the office so that it can be documented.
_____ I understand that it is important for me to let an adult in the school office, as well as my parents, know if I am having more difficulty than usual with my asthma.
_____ I agree to never share my inhaler with anyone.

Student Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____