TRINITY AREA SCHOOL DISTRICT

231 Park Avenue
Washington, PA 15301
Phone: 724-223-2000

Self-Administration of Asthma Inhaler - Student/Parent Agreement

I agree to:

- Follow my physician's/licensed prescriber's medication orders.
- Be knowledgeable of prescribed medicines proper use and side effects.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me, in a safe place that is not accessible to other students.
- ***All students must notify the school nurse immediately following each use of an inhaler, and sign off such self-administration on the medication record.***
- Notify the school nurse or health office personnel immediately if the following occur.
  - ♦ My symptoms continue or get worse after taking the medication.
  - ♦ My symptoms reoccur within 2-3 hours after taking the medication.
  - ♦ I suspect that I am experiencing side effects from my medication.
  - ♦ Other _____
- I understand that permission for possession and self-administration of my medication may be suspended if I am unable to maintain the criteria listed above.

_____ _____
Signature of Student Date

I, the parent/guardian, have read the above student agreement.

_____ _____
Signature of Parent/Guardian Date

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

_____ _____
Signature of School Nurse Date