ASTHMA INHALERS/EPINEPHRINE AUTO-INJECTORS
SELF-ADMINISTRATION BY STUDENTS

Student's Name	Grade	Date

The undersigned request permission for the above-named student to utilize (check one):

☐ ***Asthma Inhaler*** ☐ ***Epinephrine Auto-Injector***

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 medication, as indicated by the criteria listed above.

Date	Signature (Certified School Nurse)

As the parent/guardian of 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 administered. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler or auto-injector and loss of privilege to self-administer if the medication policy is violated.

Date	Parent/Guardian Signature

I agree to be solely responsible for the medication dispensing device specified above, and agree 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 or auto-injector.

Date	Student's Signature