When a prescribing health professional, parent/guardian, student and school nurse agree that self-administration of medication is appropriate for an individual student, the procedure must be done safely, carefully and accurately. A written order by a prescribing health professional and written authorization by the parent/guardian must be provided to the school. The medication must be brought to school in a container appropriately labeled by a pharmacist or the prescribing health professional. The school nurse may develop a written health care plan for the student. A student who has demonstrated competencies described in the student agreement may then be allowed to self-carry their inhaler if he/she signs the agreement on the back of this form.

This form must be completed by the prescribing health professional and parent/guardian and returned to the licensed school nurse. Orders must be renewed annually or whenever medication dosage or administration changes.

Licensed School Nurse: ___________________________ School: ______________________________
Telephone: ___________________________ FAX #: ___________________________

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I believe that ___________________________ is capable of self-administering the following medication:

(Student’s Name)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Route</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
</table>

I recommend self-administration of this medication for the treatment of:

________________________________________________________________________

Comments:_________________________________________________________________

________________________________________________________________________

Discontinuation date: ________________

______________________________
Signature of Prescribing Health Professional

______________________________
Print Name

______________________________
Phone

______________________________
Date

I hereby give permission for my child to self-carry his/her inhaler at school as prescribed by my child’s health care professional and I authorize reciprocal release of information related to the medication between the school nurse and the prescribing health professional.

______________________________
Signature of Parent/Guardian

______________________________
Date

Rev. 3/16