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 health paraprofessional if the following occurs:
  – My symptoms continue or 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 shake if applicable
  • Attaches spacer if applicable
  • Breaths out slowly
  • Presses down inhaler to release medication
  • Breaths in slowly
  • Holds breath for 10 seconds
  • Repeats as directed.
❑ Verbalizes Safe Use of Inhaler

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

________________________________________ ____________________________________
Signature of Nurse Date