HEALTH SERVICES **SY 20_____-20_____**

Prosper Independent School District

Request for Self-Administration of Prescription Metered-Dose Inhaler (MDI)

Date of Request: _____ **School:** _____ **Teacher/Grade:** _____

Student's Name: _____ **Birth date:** _____/_____/_____

Medication: _____ **Expiration Date**_____ **Route of administration:** Inhaled

Amount to be given: _____ **Time(s) to be Administered:** _____

Dates to be Administered: ☐ School Year ☐ Other date range: _____

Condition for which medication is required: _____

Known Medication Allergies: _____

Special Instructions or known side effects of medication for your child: _____

_____

TO BE COMPLETED BY THE PHYSICIAN

My signature below indicates that:

1. The student indicated above has asthma.
2. I have instructed the student indicated above in the procedure to use his/her rescue MDI and it is my professional opinion that this student is capable of carrying and self-administering the rescue medication while on school property or at school-related events.
3. The student has my permission to self-administer the rescue medication as directed above, in a properly labeled container, at the times and dosages as indicated above.

I understand that PISD reserves the right to require that this medication be kept in the clinic if in the school nurse's judgment, the student cannot or will not carry the medication in a safe manner or properly self-administer the medication.

I understand that the parent's signature in the box below gives permission for the appropriate school staff to contact me in order to obtain medical information/records. I also understand that my written request is valid only for the school year and must be renewed each school year.

Physician Name: _____ **Phone**: _____

Physician Signature: _____ **Date**: _____

TO BE COMPLETED BY THE PARENT

My signature below indicates that:

1. I give permission for my child to carry and self-administer the rescue medication specified above on school property or at a school-related event or activity according to the physician's request and the PISD medication guidelines.
2. I give my permission for appropriate school staff to contact the physician indicated above to obtain medical information/records related to this medication as necessary for care in the school setting or school-related event or activity.

It is my responsibility to ensure that the inhaler my child carries remains properly labeled, non-expired, and in good working condition. I understand that PISD reserves the right to require that this medication be kept in the clinic if in the school nurse's judgment, my child cannot or will not carry the medication in a safe manner or properly self-administer the medication. I also understand that this written request is valid only for the current school year and must be renewed each school year.

Parent/Guardian Name: _____ **Phone**: _____

Parent/Guardian Signature: _____ **Date**: _____

INTERNAL USE ONLY----------

RN Initial Review:_____ ☐ Med Checked ☐ Skyward MAR RN Reviews: _____ / _____ / _____ / _____