



## Self-Administration of Medication

### Student Agreement

**I agree to:**

- Follow my prescribing health professional’s medication orders.
- Use correct medication administration techniques.
- Maintain a written record of my medication administration at school.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or health office personnel if the following occurs:
  1. My symptoms continue to get worse after taking the medication.
  2. My symptoms reoccur within 2-3 hours after taking the medication.
  3. I suspect that I am experiencing side effects from my medication.
  4. Other: \_\_\_\_\_
- I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards established above.

\_\_\_\_\_  
*Signature of Student*

\_\_\_\_\_  
*Date*

This student has demonstrated knowledge about the proper use of his/her inhaler.

\_\_\_\_\_  
*Signature of Health Care Specialist*

\_\_\_\_\_  
*Date*