FORM M-4

Cook County Schools Health Office

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Student Self Carry and Self-Administration of Medication for

Students with Asthma and/or Severe Allergy

Name of Student:_____ Birthdate:_____Grade:_____School Year:_____

Medication	Strength	Dose	Frequency	Route	Possible Side Effects

Other Considerations/Directions:_____

- ☐ Student is knowledgeable about the above medications and the reason for administration
- ☐ Student has the skills to safely possess and use the above medications

_____ _____ _____

Licensed Prescriber Printed Name License Number Licensed Prescriber Signature

Medical Clinic Information (Name, Phone, Fax)_____

Date:_____

Parent/Guardian Authorization

1. I/we request our child to be able to carry and take their own asthma and/or allergy medication at school as prescribed above. I/we release the school personnel from liability in the event adverse reactions result from taking the medication(s) by our child outside of the health room. I/we will also provide a supplement bottle of medication or inhaler or epinephrine auto injector for the health room to store in case of loss of the medication at school.
2. I/we will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued,etc.) My/our child will sign and follow the agreement with the Registered Nurse on this form.

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3. I/we give permission for the school nurse to consult with the above named student's licensed prescriber regarding any questions that arise with the listed medication(s) or medical condition(s) being treated.

My child may self-administer their inhaler/auto-injector/ medication as needed.

_____ _____ _____

Parent/Guardian Signature Relationship to Student Date

Minnesota Statutes 121A.22: Medication must be supplied in the original prescription bottle or inhaler with student's name on it.

Self-Administration of Asthma or Allergy Medication
Student Agreement

I agree to:

1. Follow my prescribing health professional's medication orders.
2. Use correct medication administration technique.
3. Maintain a written record of my medication administration at school.
4. Not allow anyone else to use my medication.
5. Keep a supply of my medication with me in school and on field trips.
6. Notify the school health office personnel immediately if any of the following occurs:
   - Anytime I need to use my Epinephrine Auto-Injector or Medication for treatment of a severe allergic reaction (if the student has these listed as a prescribed medication)
   - My symptoms continue or get worse after taking the medication.
   - My symptoms reoccur within 2-3 hours after taking asthma medication
   - I suspect that I am experiencing side effects from my medication
   - Other _
7. 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**

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

_ _____

Signature of District Registered Nurse **Date**