Asthma Alliance of Indianapolis

Please complete and return if you would like your child to carry his/her asthma medication.
After completing this form, please return to the school office.

PERMISSION TO CARRY ASTHMA MEDICINE CONTRACT

Student:
I agree to keep my asthma inhaler, _____ (medication name), to be used responsibly for my own personal use as directed by my healthcare provider. I have been instructed in the use of this medicine and will follow my health care provider's directions. I will not share my medicine with any other person. I will tell my teacher if my inhaled medicine does not make my asthma symptoms better. I will tell my teacher when I have taken my medicine. I understand that if I do not follow this agreement, I will lose the privilege of being able to carry my medicine with me. Therefore, I realize that I am responsible for carrying out this plan.

_____ _____
Student Signature Date

Parent:
I agree that _____(student's name) has been instructed on when and how to appropriately use the asthma medication, and he/she is able to do so at school. I believe my child is responsible to self-medicate at school. I understand a label must be placed on the medication that includes the student name and a copy of the current prescription.

_____ _____
Parent Signature Date

Physician:
I agree that _____(patient's name) has been instructed on when and how to appropriately use the asthma medication, and he/she is able to do so at school. Following are the areas in which the child has been instructed for self-medication.

_____ spacer use with metered dose inhaler _____ waiting between puffs

_____ use of dry powder inhaler _____ storage of medicine

_____ peak flow monitoring

_____ _____
Physician Signature Date

School Staff Responsible for Administering Asthma Medications:
I agree that _____ (student's name) has demonstrated how to appropriately use their prescribed asthma medication. While at school _____ will self-administer their asthma medication as prescribed by their health care provider.

_____ _____
School Staff Signature Date

Contract valid for _____ school year. Please keep records updated with changes in medication.