McKinney Independent School District
School Health Services

Inhaler Self-Administration

(To be completed at the beginning of each school year and kept on file with the school nurse)

Student's Name _____ ID_____ Teacher_____
Campus_____ Birth date: _____

This plan is in accordance with new legislation, HB1688, which passed during the 2001 Texas Legislative Session. This bill allows students to self-administer asthma medications while at school or school functions with permission from physicians and parents.

SELF-ADMINISTRATION OF ASTHMA MEDICATIONS (To be filled out by physician)

Physician Please Check one:

☐ I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that _____ (student's name) ***should*** be allowed to carry and self-administer his/her _____ (name of inhaler) inhaler while on school property or at school-related events. His/her parents are aware that there will not be an inhaler available in the school clinic unless they decide to provide an extra one.

☐ It is my professional opinion that _____ (student's name) ***should NOT*** be allowed to carry and self-administer any of his/her asthma medications while on school property or at school related events. It should be kept in a designated area (i.e. school clinic) and be accessible to the student.

Physician/Practitioner: _____ _____ _____
Printed Name Signature Date

Office Address: _____Phone: _____

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To Be Completed by Parent/Guardian:
I permit my child to carry the above listed inhaler as ordered by his/her physician/practitioner. I understand that my child, not the school, is responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian Signature: _____Date: _____

Phone: _____

To Be Completed by the Student:
I understand the purpose, appropriate method, and frequency of use of this inhaler. I understand that I, not the school, am responsible for the storage, possession, and use of the inhaler. I understand that sharing medication with other students is potentially dangerous and will result in disciplinary action.

Student Signature: _____ Date: _____

To Be Completed by the School Nurse:
The student has demonstrated the proper use and care of his/her inhaler for the campus nurse.

School Nurse Signature: _____ Date: _____

If the student does not follow the above agreement, the privilege of carrying and using his/her medication will be rescinded.

☐**This form must be completed in addition to the routine medication authorization form.**