PINE CITY PUBLIC SCHOOLS ISD # 578
SCHOOL HEALTH SERVICES
GLENDA CHRISTIANSON, LICENSED SCHOOL NURSE
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HOME OF THE
DRAGONS

1400 MAIN STREET SOUTH
PINE CITY, MINNESOTA 55063

ELEMENTARY PHONE 320-629-4214 FAX 320-629-4205
HIGH SCHOOL PHONE 320-629-4116 FAX 320-629-4105

Parent authorization for inhaler use

Please indicate which option you would like for your child by **initialing** next to your choice:

_____Option #1 I request that my child come to the nurse's office where the inhaler is kept, and uses it under supervision. The advantage to this option is that the medication will be used correctly, in the proper amount, and records will be kept. A number of students keep inhalers in the nurse's office and come before PE, recess, or as needed.

_____Option #2 I would like my child to report the Health Office on a daily basis to do a peak flow. Records will be kept and will be available upon request to share with your health care provider. ***Please note:*** your child will need to remember to come to the office during his/her lunch period. Health office staff will not call students out of class to do this.

_____Option #3 I would like to have my child carry his/her inhaler. Qualified students will be allowed to carry their inhalers. Please refer to the requirements listed on the previous page. The advantage to this option is that the medication is immediately accessible.

Parental Permission to Self Carry an Inhaler- A signed Doctor's Order must accompany this form.

I give permission for my child_____ to carry and administer his/her inhaler.

I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition. **I agree to provide a second inhaler that will be kept for my child in the nurse's office should they forget theirs or run out.**

Parent/Guardian signature_____Date: _____

Student Contract

I, _____agree to :

- Use this inhaler as directed by my Doctor
- Use correct technique when administering the inhaler
- Never to allow anyone else to use my medication
- Keep a supply of medication with me while at school and on field trips
- Notify the Nurse if any of the following occurs:
- My symptoms continue or get worse after taking the medication
- My symptoms reoccur within 2-3 hours after using this medication
- I suspect that I am experiencing side effects from this medication
- I understand that permission for self-administration of medication may be suspended if I am unable to maintain the safeguards established above.
- Other

  _____

Student signature _____Date: _____

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

_____ Date: _____

Pine City Schools
Authorization for Administration of Medication at School

Name of Student:_____ Birthdate: _____

School: _____ Grade: _____ Teacher:_____

Medical Condition	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route	Start Date	Stop Date

(All authorizations expire at the end of the school year or at the end of Extended School Year summer school programs)

_____ _____

Print or Type Name of Physician / Licensed Prescriber Signature of Physician / Licensed Prescriber

_____ _____ _____ _____

Clinic Address Fax Number Phone Number Date

Parent / Guardian Authorization

I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request that the medication(s) be given on field trips, as prescribed.

I release school personnel from liability in the event adverse reactions result from taking medication(s).

I will notify the school of any change in the medication(s), (ex: dosage change, medication is discontinued, etc.).

I give permission for the school nurse or designee to communicate with the student's teachers about the student's health condition(s) and the action of the medication(s).I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.

I give permission for the school nurse or designee to consult (in oral or written format) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s), as well as ongoing data on medication effects provided to physician/licensed prescriber and parent/guardian via monitoring form.

☐ My son/daughter may self-administer his/her inhaler/Epipen®, if appropriate as assessed by the School Nurse.

_____ _____

Parent/Guardian Signature Relationship to Student

_____ _____ _____

Home Phone Day Phone Date

NOTE: Medication is to be supplied in the original/prescription bottle.

- Signatures must be completed in order to administer medication. If medication policy is not followed, school health services will not be able to administer medication, which may adversely affect educational outcomes or this student's safety.
- Pine City Fax Numbers: Elementary office(320) 629-4205 HS office (320) 629-4105