BOB JONES ACADEMY

Rev 6/2024

Asthma Self-Administration Authorization Form

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY — PLEASE PRINT	
Student Name:	**Birthdate:**
Known Allergies and/or **Asthma Triggers** include:	
Usual asthma symptoms include but are not limited to:	
Prescribed Rescue Medication:	**Spacer Recommended:** No ☐ Yes ☐

Prescribed Frequency and Dose:

☐ As needed for rescue treatment, give _____ puffs

☐ Before PE/recess/strenuous activity dose, give _____ puffs (scheduled doses should be four hours apart)

☐ Sick plan: scheduled rescue treatment, give _____ puffs every _____ hours and before PE/recess/strenuous activity

It is the responsibility of the parent to notify the school nurse if the student is on a sick plan and for how long.

For Rescue Treatment:

1. Observe the student for twenty minutes after rescue medicine administration or until breathing difficulties are relieved.
2. If the student is still experiencing breathing difficulties after 20 minutes:
   IT IS ☐ **or** IS NOT ☐ okay to repeat rescue treatment dose for up to a total of _____times to relieve breathing difficulties.

Daily Asthma Control Medication(s) prescribed for **at-home** use:

The student has permission to self-carry/self-administer this medication: ☐ No ☐ Yes — if yes, read the following carefully:

If yes box is checked, I agree that this student must be allowed to have the above-named medication/procedure on his/her person during school hours, in transit to and from school-sponsored activities, before and after-school activities on school property and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school responsible for any adverse outcome of this action.

Printed Name of Health Care Provider:_____ Phone:_____

Health Care Provider Signature:_____ **Date:**_____

Parents/Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following:*

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the school nurse(s) and/or designated staff to share this information with individuals who have responsibility for my child.
- I give the school nurse my permission to contact the prescribing Licensed Healthcare Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BJA staff to administer this medication to my child according to school policies.

My student has orders from our health care provider to Self-Carry/Self-Administer this medication:
☐ No ☐Yes *_If yes, read the following carefully:_

*Working closely with our physician, we have decided to allow my child to self-administer and self-monitor the above medication while at school. **My child has been trained by our physician and has demonstrated competency in this procedure.** My child must be allowed to possess this medication at school-sponsored activities, in transit to and from school-sponsored activities, and before and after school activities on school property. I realize that Bob Jones Academy cannot be held responsible for an adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued, or the dosage has been changed. Permission is granted to the school nurse and/or designated staff to share this information with individuals who have responsibility for my child. The first dosage will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Parent/Legal Guardian Printed Name:_____ Daytime Phone Number:_____

Parent/Legal Guardian Signature:_____ **Date:**_____

This form is only valid if signed on or after July 1st for the upcoming school year.