

**PRINCETON REGIONAL SCHOOL DISTRICT
Princeton, New Jersey**

Self-Medication for Inhaler

Date: _____

Since your child is asthmatic, it may be necessary for him/her to carry medication to counteract an asthmatic episode. Please complete this form and return it to your child's school nurse by _____.

_____ (student's name) has been instructed in the proper use of his/her inhaler for asthmatic episodes.

We, this child's parent/guardian and his/her physician, request that _____ (student's name) be permitted to carry on his/her person. He/she has been instructed in and understands the purpose, appropriate method, and frequency of the use of this medication. We consider him/her to be responsible.

Medication: _____

We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication (inhaler). This request will terminate when medication is completed or at the end of the school year and at the discretion of the school nurse.

Parent/Guardian

Health Care Provider

NOTE: This form must be completed in addition to the medication form required of any student needing medication during school hours/activities, including class trips.

Health Care Provider Stamp or Printed Name: _____

This portion of the form has been completed by the school nurse.

Student's Name

Demonstration Date

School Nurse

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