Russell County Public Schools

Annual Contract For Self-Administration and Carry of Inhaled Medication

Medical Prescriber

Student Name_____Age/Grade_____

Medication_____Frequency_____

Duration_____ Self Carry_____

Health Care Plan or Action Plan , specific for the student is provided for the school. (This plan is required by state code). Yes___ No___

Direction/Comments_____

Emergency Response_____

Prescriber Signature_____Date_____
Phone Number_____

Parent/Guardian

I have provided the school with the orders and health care plan from the physician. I understand that I will not hold the school board or its employees responsible for any negative outcomes from self-administration of the inhaled asthma medication. Furthermore, I understand that the principal may revoke the permission to possess and self-administer inhaled medication for the remainder of the school year, if it is determined that my child is not safely and effectively self-administering the inhaled medication.

_____ _____ _____
Parent/Guardian's Signature Phone # Date

To be completed by School Nurse

School Nurse Checklist

_____Prescribed Order

_____Demonstrated by student

_____Action Plan

_____Parent Signature

_____Emergency Plan

_____Teacher Informed