Asthma Inhalers at School

Dear Parents,

The following form outlines School District 207's policy on inhalers in school. Each school has a full-time nurse on the school premises at all times and we recommend Option 1 for students at the Elementary level. In compliance with Kansas Senate Bill 10, Option 2 is available for those students whose parents and physicians feel they should carry their inhalers.

Option 1:
Your child's inhaler is kept in the health room. In the event of asthma symptoms the student will come to the health room and use the inhaler under supervision. The advantage is that the student will be assessed by the nurse, the medication will be used correctly, and the proper amount and records will be kept. A physician's order is required.

Option 2:
Qualified students will be allowed to carry their inhalers. For permission to carry inhalers :

1. Student must demonstrate correct use of the inhaler to the school nurse.
2. Student must receive instruction from his/her physician
3. Student must provide a physician's order
4. Student agrees to never share the inhaler with another person.
5. Student agrees that after two puffs he/she will go to see the nurse for assessment.

The advantage to this option is that the inhaler is immediately available. It is recommended that a spare inhaler be kept in the nurse's office in the event that they lose or forget theirs.

Please check the appropriate option:

_____1. My child ______________________ will keep and use his/her inhaler in the Nurse's Office.

_____2. I give permission for my child_________________________to carry his/her inhaler. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication for my child's condition. **I understand that the school district and its officers, employees and agents are not liable for damage, injury or death resulting directly or indirectly from the self-administration of medication. Permission will be revoked in the event that steps 1-5 are not met.**

Name of Medication ________________ Dose ______________ Frequency of Use _________________________

Parent's Signature____Date_____________

Physician's Signature______________________________________Date_____________

Student's Signature____Date_____________