



Lester Prairie Schools

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Self-Administration of Medication ASTHMA Student Agreement

I agree to:

- Follow my prescribing doctor's medication orders
- Use the correct administration technique
- Not allow anyone else to use my medication
- Keep a supply of medication with me at school and on field trips
- Notify the school nurse or health office personnel if the following occurs:
 - My symptoms continue or worsen after taking my medication
 - My symptoms reoccur within 2-3 hours after taking my medication
 - I suspect that I am experiencing side effects from my medication
 - Other _____

I understand that permission for self-administration of medication may be suspended if I am unable to maintain the procedural safeguards listed above.

Signature of Student

Date

I have read the above student agreement.

Signature of Parent

Date

(See attached Medication Authorization Form)

Noted in Nurse's Office/Date