



**Lincolnshire-Prairie View School District 103
Administration Offices**

1370 RIVERWOODS ROAD • LINCOLNSHIRE, IL 60069
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<http://www.d103.org/>

Parent Agreement for Child to Carry Asthma Inhaler

*****Please include a Copy of the Prescription Label for Rescue Inhaler**

I give permission for my child _____ to carry the
(Name)
medications listed below. **I will notify the school of any changes in medication, or of my child's condition.**

Name of Medication	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____

I understand this information will be shared with appropriate school district personnel.

Yes No An extra supply of medication will be brought to school and kept in the nurse's office.

Parent/Guardian Signature _____ Date _____

Child Agreement to Carry Asthma Inhaler

- I agree to notify a district employee:
- 1.) when medication has been taken,
 - 2.) if my medication is lost or misplaced,
 - 3.) if my medication changes.

I agree not to share my medication with another person.

Child Signature _____ Date _____

The student has demonstrated proper use and technique for the self-administration of
_____(Medication Name)

Self-administration technique will be monitored and re-evaluated _____

RN signature _____ Date _____