



Community Unit School District 303 Health Services

Parent/Guardian Authorization Self- Administration of Quick Reliever Asthma Inhaler Epinephrine Auto-injector or Pancreatic Enzymes

Student _____

Name: Birth Date: School Date: _____

The following procedures shall apply to the self-administration of Quick Reliever Asthma Inhaler or Epinephrine Auto-injector or Pancreatic Enzymes:

1. Epinephrine Auto-injector: The parent/guardian must obtain a signed and dated medication order from the student's Physician / Prescriber. Order must include: name and purpose of medication, the prescribed dosage, time for administration or special circumstances under which medication is to be administered.
2. Quick Reliever Inhaler: The parent/guardian must provide either a signed and dated medication order from the student's Physician / Prescriber or a copy of the current prescription label. Order or label must include: name of medication, the prescribed dosage, time for administration or special circumstances under which medication is to be administered.
3. Pancreatic Enzymes: The parent/guardian must obtain a signed and dated medication order from the student's Physician / Prescriber. Order must include: name and purpose of medication, the prescribed dosage, time for administration or special circumstances under which medication is to be administered.
4. The Parent /guardian must provide the signed and dated authorization to self-administer medication and liability waiver.
5. The medication must be in the original labeled container as dispensed.

The School District and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self- administration of medication by the student.

Parental Authorization: I hereby acknowledge that I am the parent and /or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize School District 303 to allow my child to self-administer his or her lawfully prescribed asthma/allergy (Epinephrine) medication during the following: (1) while in school: (2) while at a school sponsored activity (3) while under the supervision of school personnel: and (4) before or after normal school activities.

I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self- administration of asthma/allergy (Epinephrine) medication. I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties from and against any and all claims, damages, causes of action or injury incurred or resulting from any child's self-administration of said medication.

We recommend that you provide an additional dose of the medication to be kept at school in the event your child forgets or loses his/her medication.

Parent/Guardian Name _____ Phone: _____

Signature: _____ Date: _____

This authorization is valid for the current school year and must be renewed each subsequent school year.