

FLOSSMOOR SCHOOL DISTRICT 161

GUIDELINES FOR
SELF-ADMINISTRATION OF ASTHMA MEDICATION

The following guidelines shall apply to the self-administration of a student's asthma medication:

1. Parent (Guardian) must sign and date the **Parental Authorization for Self-Administration of Asthma Medication.**
2. The medication is in the original labeled prescription container as dispensed or the manufacturer's labeled container. **The prescription label must contain the student name, name of the medication, prescribed dosage, and the time at which or circumstances under which the medication is to be administered.**

FLOSSMOOR SCHOOL DISTRICT 161

PARENTAL AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

STUDENT NAME: (Last) (First) (M.I.)

BIRTHDATE:

SCHOOL:

DATE:

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 Flossmoor School District 161 to allow my child to self-administer his or her legally prescribed asthma 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 Flossmoor School District 161 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 the self-administration of medication by the pupil, regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless Flossmoor School District 161 and its employees and agents, either jointly or severally, from and against any and all claims, except a claim based on willful or wanton conduct, arising out of the self-administration of medication, regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician assistant, or advanced practice nurse.

Signature: Parent/Guardian

Home Phone

Date:

Cell Phone

Signature: Parent/Guardian

Home Phone

Date:

Cell Phone