Self-Administration of Asthma Medication or Epinephrine Auto-Injector

Parent Authorization for Medication

Student _____Birthdate _____ Grade _____

Address _____

Home Phone_____EmergencyPhone_____

Medication_____

Dosage _____Frequency _____

Prescribing Physician_____

Pharmacy Name _____ Phone # _____

I acknowledge that I am primarily responsible for administering medication to my child. However, I hereby authorize Burbank School District # 111and it's employees to allow my child to self-administer his/her **asthma** medication or epinephrine auto-injector. I further verify that my child has been instructed by a health professional in the use and self-administration of his/her medication. I acknowledge and agree that, when lawfully prescribed medication is self-administered, or attempted to be self-administered, I waive any claims I might have against the School District, its employees and agents arising out of the self-administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the self-administration or attempts at self-administration of said medication by the student.*

I understand it is my responsibility to maintain an adequate supply of my child's medication, in the original pharmacy container, clearly labeled with my child name. (I understand that the school has recommended I provide an additional dose of medication to be kept at the school in the event my child forgets or loses his/her medication.) I further understand it is my responsibility to provide the school with a new physician's authorization when there is a change in my child's medication or dosage and at the start of each school year. I hereby give my consent for the school district to contact the prescribing physician regarding any questions pertaining to the above child's health condition or medication.

_____ _____

Signature of Parent/Guardian Date

*I understand that the School District, its employees and agents incur no liability, except for willful and wanton misconduct as a result of any injury arising from the administration of said medication.

Physician Authorization for Medication
School Year _____

The Illinois State Board of Education and the Illinois Department of Human Services have developed guidelines for the administration of medication during the school hours. Please complete the information below.

Student _____ Birthdate _____

Medication _____

Dosage _____ Frequency_____

Type of medication (tablet, liquid, or inhaler)_____

Diagnosis _____

Intended effect _____

Possible side effects _____

Other medication student is taking _____

Special considerations _____

I certify that the above patient has been instructed in the use and self-administration of the above medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

_____ _____

Doctor's Signature Date

Doctor's Name _____

Phone # _____

Self-administration of medication must be approved by the prescribing health care provider and the district nurse.

(05/11)