AFFIX COPY OF PRESCRIPTION LABEL HERE:

To Be Completed By Parent/Guardian:

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication (1) while in school (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication. I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration/monitoring of this medication.

_________________________________________  ________________
Parent/Guardian signature      Date

To Be Completed by Registered Nurse:

Label has been reviewed and lists the following:
Student____ Medication____ Dosage____ Route____ Frequency____ When to administer____

Self Administration Assessment completed: ____________ Outcome__________

_________________________________________  ________________
Registered Nurse signature           Date