West Aurora School District 129

WEST AURORA • NORTH AURORA • MONTGOMERY • SUGAR GROVE • BATAVIA

District Administration Office
1877 W. Downer Place
Aurora, IL 60506

Phone: 630.301.5000
Fax: 630.844.4442
www.sd129.org

STUDENT AGREEMENT TO COMPLY WITH THE RULES FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION AT SCHOOL AND AT SCHOOL RELATED ACTIVITIES

I, ________________________________, state that I have been diagnosed with asthma and have been prescribed asthma medication by a qualified health care professional. I hereby agree to comply with the following rules for self-administration of asthma medication:

1 I acknowledge that I have received education from my health care provider to self-administer medication at school.

2. I will take care to keep my asthma medication in my possession and under my control at all times.

3. I will never share my medication with another individual.

4. If I do not experience marked improvement in my condition within five minutes of self-administering my asthma medication, I will immediately see the nurse or other school employee designated to administer medication for further assessment of my condition.

I understand that if I am discovered to be abusing my asthma medication by overdosing, sharing it with others or using it improperly, my parent/guardian will be notified and I may lose the ability to self-administer my asthma medication at school.

Student Signature: ____ Date: ____________

Parent Signature: ____ Date: ____________

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AUTHORIZATION FOR STUDENT
SELF-ADMINISTRATION OF ASTHMA MEDICATION

STUDENT'S NAME: ______________________________ GRADE: ____ BIRTHDATE:________

ADDRESS: ____ PHONE:____________

I ___________________________ parent/guardian of ____________________ state that my child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry the following medication and to self-administer his/her asthma medication as prescribed by his/her physician. My child's physician has indicated that my child is capable of self-administration of his/her medication. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I will notify the school of changes in the medication or changes in my child's condition. I have provided the school with a copy of my child's prescription, which includes the information listed below. I have also provided my child's school with an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day. I understand that this permission for self-administration of medication is only effective for the ___________ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the school district, its employees and agents, arising out of my child's self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse. In addition, I agree to indemnify and hold harmless 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 of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse. .

MEDICATION: ___________________________ DOSAGE: _________________________

TIME/CIRCUMSTANCES WHEN MEDICATION SHOULD BE ADMINISTERED:_________________

____

SIDE EFFECTS: ____

DATE OF PRESCRIPTION: ___________________ DISCONTINUATION DATE: ________________

Parent/Guardian Signature: ____
Date:_____________

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AUTHORIZACION PARA PARA EL ESTUDIANTE AUTO-ADMINISTRACION DEL MEDICAMENTO PARA EL ASMA

NOMBRE DEL ESTUDIANTE: ____________________ CURSO: ____ FECHA DE NACIMIENTO: ________

DIRECCION: ____ TELEFONO: ____________

Yo ____________________________ padre/madre/tutor de ______________________ declaro que mi hijo/a ha sido diagnosticado/a con asma por un profesional de salud calificado y se le ha recetado medicamentos para el asma. Autorizo a mi hijo/a para que lleve su medicamento y que se auto-administre su medicamento para el asma que le ha recetado su medico. El medico de mi hijo/a ha indicado que mi hijo/a es capaz de auto-administrarse su medicamento. Mi hijo/a entiende que necesita el medicamento y la necesidad de informar al personal del colegio de cualquier efecto secundario. Notificare a la escuela de cualquier cambio en el medicamento o cambios en la condición de mi hijo/a. He proporcionado a la escuela con una copia de la receta de mi hijo/a, lo cual incluye la información listada abajo. También he proporcionado a la escuela de mi hijo/a con un suministro de su medicamento con la etiqueta del medicamento para usarlo en caso de que se olvide de traer su medicamento para el asma a la escuela en un día en particular. Entiendo que este permiso para administrárselo el/ella mismo/a el medicamento solo es efectivo para el año escolar ____________ y tendrá que renovarse cada año escolar subsecuente.

También se y estoy de acuerdo en que cuando el medicamento recetado se administre, renuncio cualquier reclamo que pueda tener en contra del distrito escolar, sus empleados y agentes, cuando surja de la auto-administración de mi hijo/a con dicho medicamento, aunque la autorización de esa auto-administración del medicamento sea dado por mi, como padre/madre/tutor del hijo/a, o por el medico de mi hijo/a, asistente/a del medico, o enfermera avanzada en la practica como enfermera registrada. Además, estoy de acuerdo de indemnizar y mantener indemne al distrito escolar, sus empleados y agentes, ya sea conjunto o por separado, de y en contra cualquier y todo reclamo, daños, causas de acción o daños sufridos o como resultado de la auto-administración del dicho medicamento, a excepción de una reclamación basada en la conducta voluntaria o intencional, a pesar de que la autorización del medicamento fuese dada por mi, como padre/madre/tutor, o por el medico de mi hijo/a, asistente del medico, o enfermera avanzada en la practica como enfermera registrada.

MEDICAMENTO: ____________________________ DOSIFICACION: ____________________

HORA/CIRCUMSTANCIAS CUANDO SE DEBE DE ADMINISTRAR EL MEDICAMENTO: ____________

____

SIDE EFFECTS: ____

FECHA DE LA MEDICINA: ____________________ FECHA DE DISCONTINUACION: ______________

Firma del Padre/Tutor: ____ Fecha: ______________