

BERWYN NORTH SCHOOL DISTRICT 98

**PARENTAL AUTHORIZATION FOR
SELF-ADMINISTRATION OF ASTHMA INHALER/EPIPEN® MEDICATION**

<i>Student Name</i>	<i>ID#</i>	<i>DOB</i>	<i>Grade/School Year</i>
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School: _____

Date: _____

Medication to be Self-Administered: _____

The following guidelines shall apply to the self-administration of a student’s Asthma Inhaler/EpiPen® medication:

EpiPen: #1-6 apply

ASTHMA INHALER: #2-6 apply

- 1) **FOR EpiPen:** A completed Physician Authorization and Request for Self-Administration of EpiPen form.
- 2) A Parent/Guardian has completed, signed, and dated this Parental Authorization for Self-Administration of Asthma Inhaler/EpiPen Medication form.
- 3) The medication is in the original labeled container as dispensed or the manufacturer’s labeled container.
- 4) The prescription label contains the student name, name of the medication, the prescribed dosage and the time or circumstances under which the medication is to be administered.
- 5) Annual renewal of authorization and immediate notification, in writing, of changes.
- 6) 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 the School District to allow my child to self-administer his or her lawfully prescribed Asthma Inhaler/EpiPen® 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 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 injuries incurred or resulting from my child’s self-administration of said medication.

Signature: _____
Parent/Guardian

_____ *Home/Cell Phone*

Date: _____

_____ *Work Phone*

*Recommended Guidelines for Medication Administration in Schools, IDHS & ISBE – September 2010
Self-Administration and Self-Carry of Medications for Asthma and Allergy (PA 98-0795), ISBE Guidance Document, April 2015*