GOWER SCHOOL DISTRICT 62
PARENT AUTHORIZATION AND STUDENT AGREEMENT
TO CARRY AND SELF-ADMINISTER MEDICATION OR HEALTH PROCEDURE
(To be completed annually and placed in the school health office)

Student's Name: ____ Birth Date: ______________

Student's School: ____

Medication/Health Procedure: ____

Physician's Name*: ____

Date of Authorization*: ____

**Not applicable for asthma medication or epinephrine auto-injector*

Student Agreement

As the above named student, my signature below indicates that I understand and agree to the following:

1. I have demonstrated the proper administration of the above listed medication/health procedure to the School Nurse.
2. I agree to never share or ask another student to carry my medication or health procedure equipment in school and/or at school-related activities.
3. I agree that, if there are any problems or adverse side effects during or after self-administering the medication or performing the health procedure, I will ask a teacher or other school staff member for assistance and/or to notify my parent/guardian or the School Nurse.
4. I agree to inform a teacher or other school staff member immediately if I lose my medication or health procedure equipment in school and/or at school-related activities.

Student's Signature: ____ Date: ____________

Parent /Guardian Authorization

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Gower School District 62 and its designated employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the designated employees and agents of the District) lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the District, its employees and agents, arising out of the administration of, or attempt to administer, such medication. In addition, I agree to hold harmless and indemnify the District, its employees and agents, jointly and severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of, or attempt to administer, such medication.
In the event that the District designated personnel observe an overuse or dependency upon medications, the parents will be contacted and procedures reviewed and modified as appropriate.

Print Parent/Guardian Name: ____

Parent/Guardian Signature: _______________________________________ Date: ____________

Emergency Phone Number: ____

Asthma Inhalers

A written statement from the student's physician, physician assistant, dentist, optometrist, podiatrist, or advance practice RN *is not required for a student to carry and self-administer an asthma inhaler. Parent/Guardian must attach the prescription label here, which must include the name of medication, the prescribed dosage, and the time at which/circumstances under which the medication is to be administered.*

Attach prescription label here

For only parents/guardians authorizing student to carry asthma medication or an epinephrine auto-injector:

I authorize Gower School District 62 and its employees and agents to allow my child to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (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. I hereby acknowledge that Gower School District 62, its officials, employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by my child regardless of whether authorization was given by me or by child's physician, physician's assistant, dentist, optometrist, podiatrist, or advanced practice registered nurse. **I hereby agree to indemnify and hold harmless Gower School District 62, its officials, employees, and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication or use of an epinephrine auto-injector by my child regardless of whether authorization was given by me or by child's physician, physician's assistant, dentist, optometrist, podiatrist, or advance practice registered nurse.** (105 ILCS 5/22-30)

Print Parent/Guardian Name: ____

Parent/Guardian Signature: ____ Date: ___________