ARGO COMMUNITY HIGH SCHOOL MEDICATION AUTHORIZATION FORM

(To be completed ANNUALLY and placed in the school Health Office)

Student Name ________________________________ Birthdate ____________________ ID #____________

Parent/Guardian ____

Phone ____ Emergency Phone ____________________________

ASTHMA MEDICATION ONLY: A parent or guardian must initial below to authorize a student to self-administer and self-carry asthma medication.

I hereby authorize my child to (initial to indicate agreement with those that apply) ____self-administer, _____self-carry his/her asthma medication at school and school-related events.

PLEASE ATTACH A COPY OF THE DOCTOR'S PRESCRIPTION FOR YOUR STUDENT'S INHALER.

COPY OF DOCTOR'S PRESCRIPTION FOR STUDENT'S INHALER NEEDS TO BE ATTACHED

Parent/Guardian Authorization/Signature

I agree to indemnify and hold harmless the Board of Education of Argo Community High School District #217 ("School District"), including officers, employees, agents, servants, independent contractors, and volunteers, and their successors and assigns, in their individual and official capacities from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnitees and arising out of a claim related directly or indirectly to my son/daughter's use of medication. I understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the use of medication, regardless of whether authorization was given by my student's parents or guardians or by my student's physician, physician's assistant, or advanced practice registered nurse, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.

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 the School District and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer for asthma medication or epinephrine auto-injector only with above authorization) this lawfully prescribed medication and any prescribed changes. I acknowledge that it may be necessary for the administration of medication to my child be performed by an individual other than a school nurse (i.e. school administrator). 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 School District and indemnify the School District and its employees from any and all claims, damages, and causes of action or injury incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Signature ____ Date ________________________