Queen Bee School District 16
1560 Bloomingdale Road
Glendale Heights, IL 60139

ASTHMA INHALER ADMINISTRATION FORM

STUDENT NAME: _____ BIRTHDATE: _____
SCHOOL_____GRADE:_____
PARENT NAME:_____
EMERGENCY TELEPHONE _____
DIAGNOSES_____ _____
NAME OF MEDICATION:_____
DOSAGE:_____
I,_____(parent/guardian)
of_____(student's name), hereby authorize Queen Bee Schools, District 16 and it's employees and agents, in my behalf and stead, to administer to my child or allow my child to self-administer (if applicable), while under the supervision of the employees and agents of the School District, lawfully prescribed Asthma medication/inhaler in the manner described above. 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 the administration of said medication. 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

My child is allowed to self-carry, AND self-administer prescribed ASTHMA MEDICATION (INHALER) during the school day and during school functions.

☐ **YES** (student is responsible for maintaining possession of inhaler during school day and all school functions)
☐ **NO** (inhaler will be maintained in the health office)

❖ **The inhaler box with a prescription label is required to be submitted to the health office for ALL inhalers used at school.**

Parent/GuardianSignature_____Date_____