LEMONT-BROMBEREK COMBINED SCHOOL DISTRICT 113A

AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION OF ASTHMA AND ALLERGY MEDICATION

Student's Name _____
(last) (first) (middle)

Birth Date _____ **School** ☐Oakwood ☐Old Quarry ☐River Valley **Date** _____

Per Public Acts 94-792 and 96-1460, the following requirements apply to the self-administration of a student's asthma and/or allergy (epinephrine auto-injector) medication:

1. Parent/guardian submits a signed and dated "Asthma and Allergy Medication" authorization form (this form).
2. The medication to be administered at school is in the original labeled container as dispensed or the manufacturer's labeled container.
3. The medication label contains the student's name, the name of the medication, directions for use and date.
4. Parent/guardian will immediately notify the District in writing of any changes in the authorization for administration.
5. Renewal of authorization will be annual.
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 or from the administration of school epinephrine auto-injector.
7. Inhaler: Must be in original package with prescription label attached.
   Epi-Pen: Must submit completed Emergency Action Plan with parent AND health care provider's signature.

Parent/Guardian 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 and/or allergy (epinephrine auto-injector) 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.

In accordance with Public Act 97-0361, I further acknowledge and agree that the School District and its employees and agents, including physicians providing a standing protocol or prescription for school epinephrine auto-injectors, 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 medication and/or use of allergy medication (epinephrine auto-injector), or the use or administration of a school epinephrine auto-injector, regardless of whether authorization was given by the student's parent/guardian or by the student's physician, physician's assistant or advanced practice registered nurse. I further acknowledge and agree that, in the 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 or the administration of school epinephrine auto-injector to my child. 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 or administration of school epinephrine auto-injector.

Please Initial:

☐ Please allow my child to carry his/her asthma medication during the school day and at school events.
OR
☐ Please store my child's asthma medication in the school health office where my child can access the medication as needed.

☐ Please allow my child to carry his/her allergy (epinephrine auto-injector) medication during the school day and at school events.
OR
☐ Please store my child's allergy (epinephrine auto-injector) medication in the school health office where my child can access the medication as needed.

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____ Cell Phone _____

Home Phone _____ Work Phone _____

FOR OFFICE USE ONLY

1. Attach copy of inhaler package label.
2. Sign, date and file this form.

Signature of Nurse or Administrator _____ Date _____

08/06;4/11;8/12