Jersey Community Unit District No. 100
100 Lincoln Ave. - Jerseyville, IL 62052
Phone: 618-498-5561 Fax: 618-498-5265

_____
(School Year)

Dear Parent or Guardian,

The _____ School had received your request for self-administration of _____, an asthma medication, for your child, _____.

State law requires that we inform the parents or guardians of the student, in writing, that the school district or nonpublic school 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.

Before we can allow your child, _____, to self-administer the medication, we must ask that you sign and return a copy of this document. The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. A student with asthma may possess and use his/her medication while in school, at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her medication.

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I, _____, parent or guardian of _____, acknowledge that Jersey Community School District # 100 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 above names student. I indemnify and hold harmless the school district or nonpublic school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Signed _____ Date _____

Witness _____ Date _____

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Physician Request For Self-Administration of Medication

_____ _____
Name of Student Birthdate

_____
Address

_____ _____
City Zip Telephone Number

TO

Principal _____

School _____

The above named pupil has _____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

_____
Name of Medication (Type of Medication (Tablet, Liquid, Capsule, Inhaler)

_____
Dosage Time(s) to be given

_____
Possible Side Affects

I certify that _____ has been instructed in the use and self-administration of

_____
(Name of Medication)

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may reached at the following phone # in the event of a reaction to the medication or an emergency:

_____ _____
Phone Number of Physician Signature of Physician Date

_____ _____
Address of Physician Print Name of Physician Date

I give permission for my child _____ to carry the medications described below. I will notify the school of changes in medication of my child's condition.

Parent/Guardian Signature _____ Date _____