Harrington Park Public School District
Office of the Superintendent

Permission for Self-Administration of Medication

Student's Name ______________________ Date of Birth ______________________

Epipen and Inhaler Instructions (Complete if Applicable)

I have instructed the above student in the use of his/her epipen or inhaler and he/she may be permitted to carry the medication on his/her person and self-administer it as instructed by me.

Date ______________ Physician's Name (Type or Print) ______________ Signature of Physician ______________

Request for Self-Administration of Epipen or Inhaler

I request that my child be permitted to carry and self-administer his/her epipen or inhaler at school, as authorized by my physician above. I accept full responsibility for making sure that my child carries the drug at all times. I release the district and its employees from any liability as a result of any injury arising from the self-administration of this medication.

Date ______________ Signature of Parent/Guardian ______________ Home Phone ______________ Emergency Phone ______________

Indemnification/Hold Harmless Agreement for Self-Administration of Medication

The parent(s)/guardian(s) agree(s) to indemnify, defend and hold the school district harmless from any and all claims, actions, costs, expenses, damages, and liabilities, including attorney's fees arising out of, connected with or resulting from the self-administration of medication by the pupil. The parent(s)/guardian(s) agree(s) to extend this indemnification/hold harmless agreement to the Board of Education, Board of Education employees and its agents. The parent(s)/guardian(s) agree(s) the school district, Board of Education, Board of Education employees and its agents shall incur no liability as a result of any injury arising out of or connected with the self-administration of medication by the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and in full effect prior to the granting of permission to self-administer medication.

Student's Name ______________________ Building Principal ______________________

Parent/Guardian Name ______________________ Parent/Guardian Name ______________________

Parent/Guardian Signature ______________ Parent/Guardian Signature ______________ Date of Agreement ______________

For School Use Only

Approved by the School Medical Inspector

Date ______________________ Signature of School Medical Inspector ______________________