GENOA-KINGSTON COMMUNITY UNIT SCHOOL DISTRICT #424

980 PARK AVENUE
GENOA, ILLINOIS 60135
PHONE (815) 784-6222 FAX (815) 784-6059

PHYSICIAN REQUEST FOR SELF-ADMINISTRATION OF ASTHMA MEDICATIONS

SCHOOL YEAR: ______________________ **SCHOOL:** ____________________________ **GRADE**: _______________

____ _____________________
Name of Student DOB

____
Address

____________________________ ____________ ______________________
City Zip Phone

The above named student has ____
Name of Condition or Disease

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

____ ______________________________________
Name of Medication Type of Medication (inhaler, tablet)

____ ______________________________________
Dosage Time of Administration

____
Possible Side Effects

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

____ , and to report to school personnel any unusual side effects.

He/she is capable of using this medication independently. I may be reached at the following number in the event of an emergency

____
Physicians Phone Number

____ ___________________________
Signature of Physician Date

____
Address of Physician

____
Printed Name of Physician

Ref: Illinois Department of Human Services and Illinois State Board of Education
"Recommended Guidelines for Medication Administration in Schools"

GENOA-KINGSTON COMMUNITY UNIT SCHOOL DISTRICT #424

980 PARK AVENUE
GENOA, ILLINOIS 60135
PHONE (815) 784-6222 FAX (815) 784-6059

PARENT AGREEMENT FOR STUDENT TO CARRY ASTHMA MEDICATIONS *(SCHOOL COPY)*

SCHOOL YEAR ___________________________

SCHOOL _________________________________

GRADE __________________________________

STUDENT _______________________________

Genoa-Kingston School District has received your request for self-administration of ________________________________, an asthma medication, for your child _____________________________________. State law requires that we inform the parent/guardian of the student, in writing, that 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.

Before your child____ will be allowed to self-administer the medication, you must first 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.

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 do recommend 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.

I ____ parent/guardian of ____, acknowledge that Genoa-Kingston C.U.S.D. # 424 and its employees 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 named student. I indemnify and hold harmless the school district 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.

____ ____________________________________
Parent Signature Date

____ ____________________________________
Witness Signature Date

SCHOOL COPY

Ref: Illinois Department of Human Services and Illinois State Board of Education
"Recommended Guidelines for Medication Administration in Schools"

GENOA-KINGSTON COMMUNITY UNIT SCHOOL DISTRICT #424

980 PARK AVENUE
GENOA, ILLINOIS 60135
PHONE (815) 784-6222 FAX (815) 784-6059

PARENT AGREEMENT FOR STUDENT TO CARRY ASTHMA MEDICATIONS

SCHOOL YEAR ________________________

SCHOOL ______________________________

GRADE _______________________________

STUDENT _____________________________

I give my permission for ____ to carry the
Name of Student

medication described below. I will notify the school nurse of any changes of medication or my child's condition.

____
Name of Medication

____
Dose

____
Times of Administration

____ ________________
Parent/Guardian Signature Date

PARENT COPY

Ref: Illinois Department of Human Services and Illinois State Board of Education
"Recommended Guidelines for Medication Administration in Schools"