MEDICATION PERMISSION FOR STUDENTS WITH ASTHMA
SELF-MEDICATING WITHOUT SUPERVISION

NAPERVILLE SCHOOL DISTRICT 203

STUDENT'S NAME: _____ GRADE: ____ BIRTHDATE:_____

ADDRESS: _____ PHONE:_____

I _____ parent/guardian of _____ acknowledge that

District 203 or _____ School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of an injury arising from the self-administration of medication by the above named student. I acknowledge and agree that in the absence of willful and wanton conduct on the part of the school district, or its employees or agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication.

I give permission for my child _____ to carry the following medication and to self-medicate as prescribed by his/her physician. I will notify the school of changes in the medication or changes in my child's condition.

Parent/Guardian Signature: _____ Date: _____

_____

TO BE COMPLETED BY THE PHYSICIAN

DIAGNOSIS: _____ MEDICATION: _____

ROUTE OF ADMINISTRATION: _____ DOSAGE: _____ TIME: _____

SIDE EFFECTS: _____

DATE OF PRESCRIPTION: _____ DISCONTINUATION DATE: _____

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 of reporting to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone number 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

8/02
20-40