

SAINT IGNATIUS COLLEGE PREP

SELF-ADMINISTRATION OF ASTHMA MEDICATION PERMISSION FORM

-Policy Statement for Saint Ignatius College Prep

Dear Parent/Guardian,

State Law requires that we inform the parents/guardian of the student, in writing, that the school and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of asthma medication by the student.

The permission for self-administered asthma medication is effective for the school year for which it is granted and must be renewed each school year. A student with asthma or other medical condition may possess and use his/her medication while in school, at school-sponsored activities, while under the supervision of school personnel, or before or after regular school activities. We recommend that you provide an additional dose of medication to be kept at school in the event that your child forgets or loses the medication.

READ, SIGN BELOW AND RETURN THIS FORM TO DEANS' OFFICE.

I, _____ **PARENT/GUARDIAN OF** _____
acknowledge that Saint Ignatius College Prep and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of asthma medicine by the above named student. I indemnify and hold harmless Saint Ignatius and its employees and agents against any claims arising out of self-administration of asthma medication by the student.

SIGNED: _____ **DATE:** _____

I give permission for my child to carry asthma medication as ordered by his/her physician. I will notify the school of changes in medication or my child's condition.

Parent/Guardian Signature: _____ **Date:** _____

Name of Student **Date of Birth**

Address **City** **Zip** **Phone**

PHYSICIAN'S ORDERS: (To be completed by student's physician)

The above named student has _____

I request that the student self-administer the following medication during school hours.

Medication: _____

Dose: _____ **Frequency:** _____

Possible Side Effects: _____

I certify that the above named student has been instructed in the use and self-administration of this 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.

Physician's Printed Name: _____ **Phone:** _____

Signature of Physician: _____ **Date:** _____