

STAUNTON COMMUNITY UNIT DISTRICT NO. 6
801 North Deneen Street
Staunton, Illinois 62088

SELF-ADMINISTRATION OF ASTHMA MEDICATION

PUBLIC ACT 096-1460 states a school, whether public or nonpublic, must permit the self-administration of medication by a pupil with asthma provided that:

1. The parents or guardians of the pupil provide to the school written authorization from the parents or guardians for the self-administration of medication (inhaler).
2. The parents or guardians of the pupil provide to the school:
 - The prescription label, which must contain the name of the medication.
 - The prescribed dosage.
 - The time at which or circumstances under which the medication is to be administered.

The information provided shall be kept on file in the office of the school nurse.

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 listed.

The school district and its employees and agents are to incur no liability, except for the willful and wanton conduct, as a result of any injury arising from the self-administration of medication.

The parents or guardians of the pupil must sign this statement acknowledging that the school district is to incur no liability except for willful and wanton conduct. The parents and guardians must indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful or wanton conduct.

Provided that the requirements are fulfilled, a pupil with asthma may possess and use his or her inhaler while in school, while at school-sponsored activity, while under the supervision of school personnel, or before and after normal school activities.

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AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION

Name of student _____ Birthdate _____

School _____ Grade _____ Teacher _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

Name of medication _____

Dosage and frequency of administration _____

Condition requiring medication at school _____

Time or circumstance under which medication is to be administered

Duration of order (week, month, indefinite) _____

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child.

I acknowledge that the school district 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.

Parent/Guardian Signature _____ Date _____