West Carroll Community Unit District No. 314

Student Inhaler / EpiPen Self-Carry Authorization *

Asthma inhalers and EpiPen are stored in the health office unless this form is completed by the student's parent and on file in the health office. All medication must be properly labeled with the name of the student, student's medical provider, name of medication, dosage, time to be given, adverse events and termination date for administering medication.
Please complete this form and return it to the School Health Office. This information is kept confidential between medical provide, parent, student, teacher and school nurse. Thank you.

School year_____Date_____

Medical Provider's Name_____Office Phone_____

Name of Student_____Grade_____

Name of Medication_____

Dosage_____Route_____Time to be taken_____

Purpose of Medication_____

Side Effects_____

Termination Date for this release_____

I am requesting that the school nurse or principal's designee give the above named prescription to the above mentioned student. I authorize the school district and its employee and agents, to allow my child or ward to carry and administer their asthma inhaler and/or EpiPen.

1. While in school
2. While at a school sponsored activity
3. While under the supervision of school personnel, or
4. Before or after normal school activities, such as a before/after school care operated on school property.

Illinois law requires the school district to inform parent(s),/guardian(s) that it, and it's employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (102 ILCS 5/22-30).

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do or in the event of a medical emergency, I hereby authorize the school district and its employees and agents, in my behalf, to administer or to attempt to administer to my child (allow my child to self-administer pursuant to State Law, while under the supervision of the employees and agents of the school district), lawfully prescriber medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the school district and its employee and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Student's
Name_____

Parent
Signature_____Date_____

School
Nurse_____Date_____

*This form is only acceptable for asthma inhalers, opioid antagonist and/or epinephrine auto injectors.
(Reviewed cb 4/2018)