Asthma Inhaler Self-Administration: Parent Release Form

Student Name: ____ Date of Birth: ___________________________

School Name: ____ Grade/Teacher: ____________/_____________

Parent /Guardian Name: _______________________________ Parent Phone: ____________________________

Emergency Contact: __________________________________ Emergency Phone: _________________________

Health Care Provider Name: ___________________________ Health Care Provider Phone: _________________

☐ Parent has provided the prescription label, which contains the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered.

Parent/Guardian Statement

As the parent/guardian of the above named student, I request that my student be allowed to carry and self-administer asthma rescue medication in school, at any school-sponsored activity, when 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. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees, and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication. ***I have read the policy and procedures for administration of medication in Hillsboro Community Unit School District #3 and agree to abide by them.***

PARENT SIGNATURE PRINT NAME DATE

Prescription Label Copy Here:

Epinephrine Pen Self-Administration: Parent Release Form

Student Name: ____ Date of Birth: __________________________

School Name: ____ Grade/Teacher: ____________/_____________

Parent /Guardian Name: _______________________________ Parent Phone: ____________________________

Emergency Contact: _________________________________ Emergency Phone: _________________________

Health Care Provider Name: __________________________ Health Care Provider Phone: _________________

☐ Parent has provided the prescription label, which contains the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered.

Parent/Guardian Statement

As the parent/guardian of the above named student, I request that my student be allowed to carry and self-administer allergy rescue medication in school, at any school-sponsored activity, when 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. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees, and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication. ***I have read the policy and procedures for administration of medication in Hillsboro Community Unit School District #3 and agree to abide by them.***

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PARENT SIGNATURE PRINT NAME DATE

Prescription Label Copy Here: