CONTRACT FOR SELF-ADMINISTRATION OF MEDICATION

PAWNEE COMMUNITY UNIT SCHOOL DISTRICT #11

PHONE: 625-2471 FAX: 625-2251

STUDENT'S NAME _____ _____ _____
Grade **Date of Birth**

The following section is to be completed by the STUDENT:

I agree to never share my inhaler with another person and I will use it only as prescribed and instructed by my doctor. I will tell the teacher, school nurse, or other responsible adult if there is no improvement after using my inhaler as instructed.

_____ _____
Student's signature Date

The following section is to be completed by the PARENT:

I give my permission for _____ to carry the inhaler and self-administer the medication as described below. I understand that self-administer means that he/she has the discretion as to the use of the medication. By signing below I authorize the Pawnee School District and its employees and agents to allow my child or ward to possess and use his/her asthma medication while in school, at a school sponsored activity, and before or after normal school activities. The Pawnee School District and its employees and agents incur no liability, except for willful and wanton conduct, as a result of an injury arising from a student's self-administration of medication. I agree to indemnify and hold harmless the Pawnee School District and its employee and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child. (Legal reference 105 ILCS 5/22-30)

_____ _____
Parent/Guardian Signature Date

The following section is to be completed by the PHYSICIAN:

NAME OF MEDICATION _____

DOSAGE _____ INSTRUCTIONS FOR USE/FREQUENCY _____

DIAGNOSIS for which medication is intended _____

EXPECTED SIDE EFFECTS_____

******Please provide additional information for the child's asthma action plan at school:***

KNOWN TRIGGERS _____

PEAK FLOW RANGE _____

SPECIAL INSTRUCTIONS _____

I certify that the above name pupil has been instructed in the use of self-administration of the above named medication. He/She understands the need for medication and necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

_____ _____ _____ _____
Physician Signature Date Phone Fax