Dear Parents/Guardians:

You may request and authorize the school to permit a student in your care and custody to self-administer asthma medication prescribed the student's physician. If this is allowed, you must understand that the School, the parish of which it is a part, the employees and agents of the school, the Diocese of Belleville, and the Bishop of Belleville are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

In order to allow this the school, in accord with the state statute, requires all of the following before it can give effect to your request and authorization:

1. A written authorization from the parents or guardians of the student.

2. A statement, contained in our authorization form, that the parents or guardians
   - Acknowledge that School, the parish of which it is a part, the employees and agents of the School, the Diocese of Belleville and the Bishop of Belleville are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student; and
   - Agree to indemnify and hold harmless School, the parish of which it is a part, the employees and agents of the School, the Diocese of Belleville and the Bishop of Belleville.

3. A written statement from the physician, physician assistant, or advanced practice registered nurse must contain the following information:

   - The name of the student/patient;
   - The name and purpose of the medication;
   - The prescribed dosage; and
   - The time or times at which or the special circumstances under which the medication is to be administered.

   This information will then be kept on file in the office of the principal.

Parents and guardians also must understand that as a matter of our discipline policy any abuse of this statutory right by a student and/or any endangerment of other students as a result of a student possessing this medicine may result in appropriate disciplinary action by the School.

If you have any questions regarding this, do not hesitate to contact me. If you wish to see a copy of the statute, please contact me.

Sincerely,

Principal

AUTHORIZATION FOR SELF-ADMINISTRATION OF ASTHMA MEDICINE

I, ________________________________ or we, ___________________________________ and ___________________________________, parents or guardians of __________________________ (hereinafter "Student"), a student at ____ School (hereinafter "School") hereby request and authorize School to permit Student to self-administer asthma medication prescribed by the Student's physician, physician assistant, or advanced practice registered nurse, which is described more fully in a written statement provided by the Student's physician, physician assistant, or advanced practice registered nurse, which has been given or will be given shortly to the School. We (I) understand that this authorization will not be effective and the School cannot act upon it until the School has received the above described written statement from the Student's physician, physician assistant, or advanced practice registered nurse.

We (I) understand and acknowledge that the School, the Parish of which it is a part, their agents and employees, the Diocese of Belleville, the Bishop of Belleville are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from self-administration of medication by Student.

We (I) ;hold harmless and indemnify the School, the Parish of which it is a part, their agents and employees, the Diocese of Belleville, the Bishop of Belleville against any and all claims except based on willful and wanton conduct, arising out of self-administration of medication by the Student.

We (I) understand that any abuse of this right by the; Student or any endangerment of another student or students by means of the Student's possession of this medication may result in appropriate disciplinary action under our discipline policy.

This authorization is effective only for the school year _______________________.

Date: ____________________________

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Parents or Guardians

PHYSICIAN'S STATEMENT

This information must be provided to the school when the student returns to school with medication. This form must be filled out and signed by the physician. The completed form must be on file with the school prior to any medications being taken by a student.

Name of Student ____________________ Grade ______ Date ____________

Name of Medication ____________________

Dosage ____________________ Time of Administration ____________________

Method of Administration ____________________ Date to Discontinue ____________________

Predictable Side Effects ____________________

Contraindications ____________________

Physician's Signature ____________________ Telephone Number ____________________

Address ____________________ City/State/Zip ____________________