



Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique

SPECIAL SERVICES DEPARTMENT
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SELF ADMINISTRATION OF ASTHMA MEDICATION AUTHORIZATION, HOLD-HARMLESS AND INDEMNITY

Student's name: Date of birth:

Emergency Contact: Phone Number:

For student use of asthma medication, this Section must be completed and signed by either: (i) the student's physician; (ii) physician assistant; or (iii) advanced practice registered nurse:

Licensed Prescriber's Name: Phone number:

Address: Emergency Phone Number:

Name of Asthma medication: Dosage:

Instructions of administration on school grounds:

Side effects from asthma medication for which student must be observed:

Signature of physician, physician's assistant or advanced practice registered nurse

Date

This Section must be completed by the student's parent or guardian:

Pursuant to the authority granted under Public Act 97-0361 and Public Act 98-0795, I hereby authorize my child as named above, to self-administer asthma medication in school, while at a school-sponsored activity, while under the supervision of school personnel, or at certain before or after normal school activities on school operated property. I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees and volunteers from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnitees and arising out of a claim related directly or indirectly to my son/daughter's self-administration of asthma medication brought by me, any other parent or guardian of my student or another student, or by or on behalf of my student or another student. I understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the self-administration of asthma medication, regardless of whether authorization was given by my student's parents or guardians or by my student's physician, physician's assistant, or advanced practice registered nurse, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.

Signature of Parent/Guardian

Date

Please fill out this form ONLY if your child will be self-carrying and self-administering their asthma medication. This form shall be effective for the current school year only, and must be renewed each subsequent school year.