



**DIOCESE OF DAVENPORT  
BOARD OF EDUCATION**

**SERIES 500: STUDENT PERSONNEL**

- I request the above student possess and self-administer asthma or other airway constricting disease medication(s) at school and in school activities according to the authorization and instructions.
- I understand the school and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or for supervising, monitoring, or interfering with a student's self-administration of medication.
- I agree to coordinate and work with school personnel and prescriber when questions arise, or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).
- I agree to provide the school with back-up medication approved in this form.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Additional Information

\_\_\_\_\_  
Work Phone/Other Phone