Blessed Sacrament School

Authorization for Self-Administration of Asthma Medicine

I, _____, or we, _____ and _____, parents or guardians of _____

(hereinafter "Student"), a student at Blessed Sacrament School, hereby request and authorize Blessed Sacrament School (hereinafter "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 Springfield in Illinois, and the Bishop of Springfield in Illinois 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 Blessed Sacrament School, the Parish of which it is a part, their agents and employees, the Diocese of Springfield in Illinois, and the Bishop of Springfield in Illinois 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 **2020-2021**.

Date: _____ _____

_____

Signature of Parents or Guardians

• Inhaler must be kept with the student and be concealed in a small tote bag/cosmetic bag.

• Student will not allow other students access to his/her inhaler.

_____

Student Signature

STATEMENT OF PHYSICIAN

_____ _____ _____

Name of student | School | Child's Date of Birth

_____ _____ _____

Diagnosis | Name of Medication | Dosage

_____ _____

Predictable Side Effects | Contraindications

_____ _____ _____

Physician's Signature | Physician's Phone | Date

Physician's Address _____