Education that inspires…Opportunities for all

GURNEE SCHOOL DISTRICT 56

3706 Florida Avenue • Gurnee, IL 60031 • 847-336-0800 • www.d56.org

School Year _____

Parent/Guardian Authorization for Self-Administration of Rescue Inhaler/Epi-Pen

Student _____ D.O.B. _____
School _____ Grade _____Homeroom/Team_____

I am requesting that the above named student carry and use the medication as prescribed on the medication prescription label and/or per physician directions. I have submitted the medication with the prescription label that contains my child's name, the name of the medication, the prescribed dose, the time at which or circumstances under which the medication is to be administered. I am requesting that my child carry and use the medication while under the supervision of school personnel.

He/she is capable of using this medication independently, understands the time or specific circumstances under which the medication is to be used and the necessity to report to school personnel any unusual side effects. I understand, according to school policy, if this poses a danger to him/herself or other students, the medication will be kept in the Health Office and I will be notified. Gurnee School District 56 employees and agents 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, regardless of whether authorization is given by the parent or the physician.

_____ _____ _____
Parent/Guardian Signature **Date** **Daytime Phone Number**

Physician Authorization for Self-Administration of Epi-Pen or Rescue Inhaler

I am requesting that the above named student carry and use the medication as prescribed on the medication permission form (see other side) while under the supervision of school personnel. I certify that this student has been instructed in the use and self-administration of an _____ **Epi-Pe**n _____**Rescue Inhaler**

He/she is capable of using this medication independently, understands the time or specific circumstances under which the medication is to be used and the necessity to report to school personnel any unusual side effects. I understand according to school policy that the medication will be removed from the student if it poses a danger to him/herself or others.

_____ _____ _____
Physician Signature **Date** **Daytime Phone Number**

Distinguished Program