GLENVIEW 34
SCHOOL DISTRICT

POLICY STATEMENT FOR ASTHMA MEDICATION/EPINEPHRINE AUTO-INJECTOR

At School_____

Date: _____

Dear Parent or Guardian,

The _____School has received your request for self-administration of

_____, asthma medication, for your child _____.

_____, an epinephrine auto-injector, for your child _____.

State law requires that we inform the parents or guardians of the student, in writing, that Glenview School District #34 and its 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.

Before we can allow your child, _____to self-administer the medication, we must ask that you sign and return a copy of this document.

The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. A student who needs an epinephrine auto-injector or has asthma may possess and use his/her medication while in school, at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. We recommend that you provide an additional dose of the medication to be kept at the school in the event that your child forgets or loses his/her medication.

I, _____parent or guardian of _____,

acknowledge that Glenview School District #34 or _____School and its 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 above named student. I indemnify and hold harmless the school district or public or nonpublic school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Parent/Guardian Signature:_____ Date:_____

Witness: _____ Date:_____
School Principal, Health Office or School Designee