WHITESIDE SCHOOL DISTRICT 115
111 Warrior Way
Belleville, Illinois 62221
Telephone 618 239-0000
Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931

PARENT/GUARDIAN AUTHORIZATION FORM

SELF-ADMINISTRATION OF ASTHMA MEDICATION

Student Name: _____ DOB: _____

Teacher: _____ Grade: _____

My child, as listed above, has a medical condition that at times requires the use of a rescue inhaler. In accordance with Illinois Public Act 096-1460, I authorize my child to have in their possession a prescribed asthma inhaler. I give my permission for him/her to self medicate as needed and as directed by their healthcare provider's instructions. I have attached the pharmacy prescription label as required.

I understand that the school district, its employees and its agents, are to incur no liability, nor claims against them, except for willful and wanton conduct, as a result of any injury arising from the self administration of the medication regardless of whether authorization was given by the parent/guardian. I understand that this request is effective for the school year for which it is granted and must be renewed each subsequent school year or with any changes in medication dosing, frequency or instructions for use during the current school year. Upon the fulfillment of all requirements, my child may possess and administer his/her medication while in school, while at school-sponsored activities, while under the supervision of school personnel, or before or after normal school activities such as in the extended school program. I am aware that my child understands the need for this medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently and responsibly and will seek assistance when needed.

Parent Signature: _____ **Date:** _____