Immaculate Conception Catholic School

Medication Permission for Students With Asthma

Self-Medicating Without Supervision

Student's Name:_____Grade:_____DOB:_____/_____/_____

Address:_____Phone:_____

I, _____, parent/legal guardian of_____, acknowledge that Immaculate Conception Catholic School and it's staff/personnel 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 acknowledge and agree that in the absence of willful and wanton conduct on the part of the school, or it's staff/personnel, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication.

I give permission for my child,_____, to carry the following medication and to self-medicate as prescribed by his/her physician. I will notify the school of any changes in the medication or changes in my child's health condition.

Parent/Guardian Signature: _____ Date:_____/_____/_____

Print Name:_____Phone:_____

****To Be Completed By the Physician:**

Diagnosis:_____Medication:_____

Route of Administration: _____ Dosage:_____Time:_____

Side Effects: _____

Original Date of Prescription:_____/_____/_____ Discontinuation Date:_____/_____/_____

I certify that _____ has been instructed in the use and self-administration of _____ (name of medication).

He/She understands the need for the medication and the necessity of reporting to school staff/personnel any unusual side effects. He/She is capable of using this medication independently.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

Printed Name of Physician:_____Phone:_____

Physician's Signature:_____ Date:_____/_____/_____