

(Copy on Blue)

**MEDICATION PERMISSION FOR STUDENTS WITH ASTHMA  
SELF-MEDICATING WITHOUT SUPERVISION**

**NAPERVILLE SCHOOL DISTRICT 203**

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

I \_\_\_\_\_ parent/guardian of \_\_\_\_\_ acknowledge that District 203 and \_\_\_\_\_ School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of an injury arising from the self-administration of medication by the above named student, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse. I acknowledge and agree that in the absence of willful and wanton conduct on the part of the school district, or its employees or agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

I give permission for my child \_\_\_\_\_ to carry the following medication and to self-medicate as prescribed by his/her physician. My child's physician has indicated that my child is capable of self-administration of his/her medication. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I will notify the school of changes in the medication or changes in my child's condition. I have provided the school with a copy of my child's prescription, which includes the information listed below. I understand that this permission for self-administration of medication is only effective for the \_\_\_\_\_ school year and will need to be renewed each subsequent school year.

MEDICATION: \_\_\_\_\_ DOSAGE: \_\_\_\_\_

TIME/CIRCUMSTANCES WHEN MEDICATION SHOULD BE ADMINISTERED: \_\_\_\_\_

SIDE EFFECTS: \_\_\_\_\_

DATE OF PRESCRIPTION: \_\_\_\_\_ DISCONTINUATION DATE: \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_

NURSE INITIALS: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_