

**AMBOY CUSD #272**  
**ASTHMA INHALER OR EPINEPHRINE PEN AUTHORIZATION FORM**

Students Name \_\_\_\_\_ Grade \_\_\_\_\_

Physician \_\_\_\_\_ Physician Office Phone \_\_\_\_\_

**Asthma Inhalers**

*Parent/Guardians please attach prescription label here*

**Students who need Asthma Medication or an Epinephrine Auto-injector:**

I authorize Amboy School District and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector:

- while in school
- while at a school sponsored activity
- while under the supervision of school personnel
- before or after normal school activities on school-operated property

Illinois law requires the school district to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30.) If you agree please initial: \_\_\_\_\_

Parent/Guardian

**For All Parents/Guardians:**

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Amboy School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self administer his or her own asthma inhaler or epinephrine pen while under the supervision of the employees and agents of Amboy CUSD 272), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices** and I agree to indemnify and hold harmless the Amboy CUSD 272 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian printed name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

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