

**FILL THIS FORM OUT ONLY IF YOUR CHILD HAS
ASTHMA.**

**BLOOM TOWNSHIP DISTRICT 206 AGREEMENT AUTHORIZING THE
SELF-ADMINISTRATION OF ASTHMA MEDICATION**

Student Name _____

School _____

- I/ We, _____, the parent(s) or legal guardian(s) of _____, a student of Bloom Township District 206, hereby authorize my/ our child to self-administer asthma medication while at school and school related activities.
- I/ We have provided a doctor's statement in compliance with the state statute. It lists:
 - 1) the name and purpose of the medication.
 - 2) the prescribed dosage.
 - 3) the time or times at which, or the special circumstances under which, the medication is to be administered.
 - I/ We understand that according to the state statute the School District 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 the asthma medication by my/ our child.
 - I/ We further understand and agree that as the parent(s) or legal guardian(s) of my/ our child, I/ we must indemnify and hold harmless the School District and its employees and agents against any claims; except a claim based on willful and wanton conduct arising out of the self-administration of asthma medication by my/ our child.
 - I/ We further that this permission for self-administration of asthma medication is effective for this school year only and must be renewed each subsequent school year if desired.
 - I/ We understand that a copy of this permission will be kept in my/ our child's medical file.

Print Name(s) _____

Signature(s) _____