Bethalto Community Unit School District #8

School Health Services

CMHS EAST PARKSIDE
MEADOWBROOK TMS

Asthma Inhaler Administration: Parent Release Form

Student Name: _____Date of Birth: _____

School Name: _____Grade/Teacher: _____

Parent/Guardian Name: _____

Parent/Guardian Phone #: _____

Emergency Contact: _____ Emergency Phone #:_____

Health Care Provider Name:_____

Health Care Provider Phone: _____

☐ Parent has provided the prescription label, which contains the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered.

OR

☐ Parent has provided order for inhaler from their doctor.

I DO / DO NOT wish for my student's rescue inhaler to be kept in and administered out of the Nurse's Office. (please indicate your preference)

Parent Statement

As the parent of the above named student, I request that my student be allowed to carry and self-administer asthma rescue medication in school, at any school-sponsored activity, when under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school-operated property. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication. ***I have read the policy and procedures for administration of medication in Bethalto CUSD #8 and agree to abide by them.***

_____

Parent Signature *Print Name* *Date*

Student Statement

Student has demonstrated the correct use of inhaler to the health care provider and school health personnel.
Student agrees to **never** share the inhaler with another person.
Student agrees that if there is not marked improvement after 2 puffs, he/ she will notify a teacher or other responsible adult who will seek further medical intervention as outlined in the student's Asthma Action Plan.

_____

Student Signature *Print Name* *Date*