RCS Student Agreement to Carry
Asthma Inhaler for Self-Administration

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

Student signature_____ Date:_____

I give permission for my child_____to carry the inhaler described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

MEDICATION_____

DOSE _____

FREQUENCY OF USE:_____

PARENT AUTHORIZATION AND SIGNATURE:

I authorize Rockford Christian School and its employees, on my behalf and stead, to administer or attempt to administer or to allow my child to self-administer while under the supervision of the employees and agents of this school) to my child this lawfully prescribed medication and any prescribed changes. 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. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify Rockford Christian School and its employees from any and all claims, damages, and causes of action or injury incurred or resulting from the administration or attempts at administration of said medication.

Rockford Christian School, 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 medication by the pupil, regardless of whether authorization was given by the physician, physician's assistant or advanced practice registered nurse.

I allow the school nurse to discuss this medication and its effects on my child with the prescribing physician or his representatives.

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Day-Time Phone Number) (Emergency Phone Number)