



UNITY

STARTS

WITH

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Ellen Ramsden-Belotti
Director of Special Education

**DEPARTMENT OF
SPECIAL EDUCATION**

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**AGREEMENT TO AUTHORIZE
THE SELF-ADMINISTRATION OF ASTHMA MEDICATION**

Student's Name _____

School _____

I/We, _____, the parent(s)

or legal guardian(s) of _____, a student of Crete-Monee School District 201-U, hereby authorize my/our child to self-administer asthma medication while at school and school-related activities.

I/We have provided the rescue inhaler in the box with the prescription label affixed to it, verifying authenticity as required by Illinois state statute.

I/We understand that according to 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 parents(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 understand 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 agree to instruct my/our child that he/she must report to the Health Office (school office) each time he/she has self-administered his/her asthma medication.

I/We understand that a copy of this permission will be kept in my/our child's medical file.

Parent/Guardian(s) Signature _____

Print Name(s) _____ Date _____

DC/js