



RIVER
FOREST
PUBLIC
SCHOOLS

Administration Building
7776 Lake Street
River Forest, Illinois
60305
708 • 771 • 8282
Fax 708 • 771 • 8291

HEALTH CHECKLIST 2009 - 2010

Forms due to the School Office by August 25, 2009

- Physical Form** – Kindergarten, 6th Grade, New Students, Interscholastic Participation
- Dental Form** – Kindergarten, 2nd Grade, 6th Grade
- Vision Form** – Kindergarten, New Students
- Emergency and Health Information** – Please complete annually.
- Medication Permission Form** – Please complete if medication needs to be given at school.
- Agreement Authorizing Self-Administration of Asthma Medication and Epi-Pen** – Please complete authorization agreement for child to self-administer.



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HEALTH INFORMATION

Please find enclosed the necessary health forms that are to be completed and returned to your school office. The State laws are quite specific about physical examinations and immunization records for students prior to their entrance into the public schools. **Children's health records should be completed by August 25, 2009 for the start of the school year.**

PHYSICAL EXAMINATION AND IMMUNIZATIONS REQUIRED FOR KINDERGARTEN AND 6TH GRADE.

Physical Examination

Parents are reminded that Illinois law regarding physical examinations does not permit any child to enter kindergarten, first grade (if the child has not attended kindergarten), sixth grade, or any grade level if the child is new to the District until the appropriate health forms (reported on the Illinois Certificate of Child Health or comparable form) are submitted to the school office. The medical history section of the form must be completed and signed by the parent or legal guardian of the student. School District 90 complies with all articles of the statute, and children whose health forms are not complete prior to October 15, 2009, will not be admitted to any school. Please be advised to keep a copy of the examination form for your records. **(Form enclosed)**

DIABETIC SCREENING NOW REQUIRED

Recent changes to State law require diabetic screening as part of each child's health examination. Diabetes test, however, is not required.

DENTAL EXAM REQUIRED FOR KINDERGARTEN, 2ND AND 6TH GRADERS.

An oral health exam is required for all incoming kindergarten, second graders and sixth graders. Parents will be required to obtain a signed report on a State form by a licensed dentist. **(Form enclosed)**

EYE EXAMINATION REPORT

Effective January 1, 2008, all children enrolling in kindergarten and any children enrolling in a public, private, or parochial school must have an eye examination and present proof of the eye examination to the school by October 15 of the school year. **(Form enclosed)**

Emergency and Health Information Form

Each child must have an emergency health information form on file in the school nurse's office, which is updated annually. This information helps to identify and assist student(s) regarding any significant health problems. It is imperative that the nurse be informed of any significant changes in your child's health in order to ensure appropriate care as needed. This form also identifies other adults, authorized by you, who may take your child from school. This includes normal pickup days, illness or any disaster situation. Your child will NOT be allowed to leave school with anyone other than you, the parent or legal guardian, unless you have listed them on the Emergency Form. This release may be changed and updated by the parent or guardian at any time during the school year. **(Form enclosed)**

Physical Examination – Interscholastic Sports (Grades 5 – 8 Only)

In order to try out and participate in interscholastic sports or practices, a sports physical (or a full physical exam), dated within twelve months through the sport season, must be on file in the School Office in order to participate. A note stating that the exam was done is not sufficient. It is advised to get a physical exam every summer so that it is valid for the entire school year and, if your child decides at a later date that they would like to try out or participate in a sport, a physical will be on file. **(Form enclosed)**

Medication Permission Form

This includes prescription and over the counter medications (Tylenol, cough medicine, etc.) that need to be taken during school. All medication must be sent to school in a container appropriately labeled by the pharmacy. If it is over the counter medication, it needs to be sent in the original package with your child's name on it. Parents must provide written authorization by the physician with diagnosis and directions for dispensing of medication. Authorization forms must also be signed by the parent/guardian. Forms must be renewed every school year. **(Form enclosed)**

Agreement Authorizing Self-Administration of Asthma Medication and Epi-Pen

The Agreement Authorizing Self-Administration of Asthma Medication and Epi-Pen, in addition to providing a Medication Permission Form, allows your child to self-administer asthma medication (inhaler) and/or Epi-Pen while at school. This agreement allows your child to **carry an inhaler and/or Epi-Pen with them** instead of keeping it in the nurse's office, although it's advised to keep an extra inhaler in the nurse's office in case it is lost or medication has run out.

All above forms for the **Physicals** (including sports – same form), **Dental Exams, Eye Exams, Medication Permission** and **Self-Administration of Asthma Medication and/or Epi-Pen** (inhalers and/or Epi-Pen to be carried with student) are included in this packet or can be accessed online at <http://www.district90.org> - parent information – forms – medical.

Please make the necessary arrangements to have all examinations completed before school starts on August 25, 2009. Children whose health forms are not complete prior to October 15, 2009, will not be admitted to any school. If you have any questions relative to your child's physical examination or other health records, please call your school nurse.

Please submit all health forms to the school your child will be attending.

- Enclosed:
- Certificate of Child Health Examination
 - Required Immunizations
 - Proof of School Dental Examination Form/Waiver
 - Eye Examination Report/Waiver
 - Emergency and Health Information
 - Medication Permission Form
 - Agreement Authorizing Self-Administration of Asthma Medication and Epi-Pen



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

Student's Name			Birth Date	Sex	School	Grade Level /ID#
Last	First	Middle	Month/Day/ Year			

Address			Parent/ Guardian	Telephone # Home	Work
Street	City	ZIP code			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		Comments
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title Date

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																	Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade																	
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																	
Hearing																	

Printed by Authority of the State of Illinois

(Complete Both Sides)

Student's Name			Birth Date		Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year				

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night coughing	Yes	No		Hospitalizations? When? What for?	Yes	No	
Birth defects?	Yes	No	Developmental delay?	Surgery? (List all.) When? What for?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	Seizures? What are they like?	Serious injury or illness?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		TB skin test positive (past/present)?	Yes*	No	
Heart murmur/High blood pressure?	Yes	No	TB disease (past or present)?	Yes*	No		
Dizziness or chest pain with exercise?	Yes	No	Heart problem/Shortness of breath?	Tobacco use (type, frequency)?	Yes		No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Alcohol/Drug use?	Yes	No	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Family history of sudden death before age 50? (Cause?)	Yes	No	
Ear/Hearing problems?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other				
Bone/Joint problem/injury/scoliosis?	Yes	No	Other concerns?				
Information may be shared with appropriate personnel for health and educational purposes.							
Parent/Guardian Signature				Date			

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS	HEIGHT	WEIGHT	BMI	B/P
--	---------------	---------------	------------	------------

DIABETES SCREENING BMD>85% age/sex Yes No And any two of the following: **Family History** Yes No **Ethnic Minority** Yes No
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No **At Risk** Yes No

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Blood Test Indicated? Yes No **Blood Test Date** _____ **Blood Test Result** _____ (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** _____ mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results	Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)	
Urinalysis			Other	

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomestrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Result _____	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes No If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in **PHYSICAL EDUCATION** Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited (If No or Modified, please attach explanation.)

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name	Signature	Date
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Address	Phone
---------	-------

(Complete both sides)

STATE OF ILLINOIS

Required Immunizations Entering Kindergarten through 8th Grade

Polio 3 or more doses with the last dose being a booster and having been received on or after the 4th birthday, intervals of no less than 6 wks, last dose at least 6 mo since previous dose, but prior to school entrance.

DTP/DTaP/Td 4 or more doses with the last dose being a booster and having been received on or after the 4th birthday. Intervals no less than 4 weeks, last dose at least 6 mo since previous dose.

Measles 2 doses, 1 dose administered 12 months or older, 2nd dose no less than 1 mo. after 1st dose (equal to or greater than 28 days), diagnosis made on/after July 1, 2002 must be confirmed with laboratory evidence).

Rubella 1 dose, administered 12 mo or older.

Mumps 1 dose, administered 12 mo or older.

Hepatitis B (Children entering 5th grade for the first time after July 1997)
(Not required for K-4) Must show evidence of having received 3 doses of Hepatitis B, first 2 doses must be at least 4 weeks apart, between 2nd and 3rd, at least 2 mo. Proof of prior/current infection, if verified by lab evidence, may be submitted for proof of vaccination.

Hib (not required for K-8)
Not recommended for children 60 months of age or older

Varicella (chickenpox) (Entering Kindergarten for the first time)
Children entering kindergarten for the first time on/after July 1, 2002, must show evidence of having received 1 dose on/after 1st birthday or other proof of immunity.

*** **Varicella-** A physician, health care provider or school health professional can confirm past disease history (in lieu of vaccination) by having examined the infected child, documenting the parent's description of the child's history or reviewing laboratory evidence.

Illinois Department of Public Health DENTAL EXAMINATION WAIVER FORM



Please print:

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

I am unable to obtain the required dental examination because:

- My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/KidCare).
- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/KidCare).
- My child is enrolled in Medicaid/KidCare, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/KidCare.
- My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature _____

Date _____

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the child beginning school.

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

To Be Completed By Examining Doctor

Case History

Date of Exam: _____

Ocular History: Normal or Positive for: _____
 Medical History: Normal or Positive for: _____
 Drug Allergies: None or Allergic to: _____
 Other Information: _____

Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IOP (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia
 Other: _____

Recommendations

- Corrective Lenses: No Yes, glasses should be worn for: Constant Wear Near Vision Far Vision
 May Be Removed for Physical Education
- Preferential seating recommended: No Yes Comments: _____
- Recommend re-examination: 3 months 6 months 12 months Other _____
- _____
- _____

Print Name: _____
Optometrist or Physician Who Provides Eye Examinations

Address: _____

Signature: _____
Optometrist or Physician Who Provides Eye Examinations

Consent of Parent or Guardian
 I agree to release the above information on my child or ward to appropriate school or health authorities.

(Parent or Guardian's Signature)

Phone: _____



**State of Illinois
Department of Public Health
Eye Examination Waiver Form**

Please print:

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

I am unable to obtain the required vision examination because:

- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).
- My child is enrolled in Medicaid/All KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community that is able to see the child and accepts Medicaid/All KIDS.
- My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature _____

Date _____

EMERGENCY AND HEALTH INFORMATION

Student Name _____

Doctor's Name _____ Doctor's Phone _____

Dentist's Name _____ Dentist's Phone _____

If my child becomes ill or injured at school and needs emergency care and I cannot be reached, contact my doctor or transport to a hospital by paramedics. I agree to assume all responsibility and expenses incurred at this time including transportation to a hospital so designated by my doctor or the River Forest Fire Department paramedics. Permission is hereby granted to the attending physicians to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student.

Parent/Guardian Signature _____ Date _____

In the event of illness or other emergency, and a parent/guardian cannot be reached, whom may we contact for consent for medical treatment?

Contact #1
Name _____ Relationship _____ Day Phone _____

Contact #2
Name _____ Relationship _____ Day Phone _____

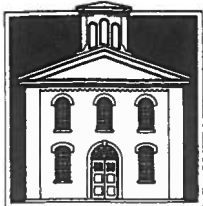
STUDENT HEALTH HISTORY	CIRCLE	COMMENTS
Allergies? To what?	Yes / No	
Has Epi-Pen ever been prescribed? Ever used? If yes, explain.	Yes / No	
Diagnosis of Asthma? Indicate severity.	Yes / No	
Wheezing/Cough during or after exercise?	Yes / No	
Birth defects?	Yes / No	
Developmental delay?	Yes / No	
Blood disorders? Please explain.	Yes / No	
Diabetes?	Yes / No	
Hypoglycemia?	Yes / No	
Head injury/concussion/passed out?	Yes / No	
Seizures? What are they like?	Yes / No	
Any history of heart problems or shortness of breath?	Yes / No	
Heart murmur? High blood pressure?	Yes / No	
Any dizziness, fainting or chest pain with or without exercise?	Yes / No	
Bone/joint problems/injury?	Yes / No	
Ear/hearing problems?	Yes / No	
Eye/vision problems?	Yes / No	
Glasses/contacts?	Yes / No	
Date of last eye exam?		
Loss of function in one of paired organs?	Yes / No	
Hospitalization? When and for what?	Yes / No	
Surgery? When and for what?	Yes / No	
Serious injury or illness?	Yes / No	
Family history of sudden death before age 50?	Yes / No	

Is your child taking medication at home? No ___ Yes ___: Name, dose and reason for medication:

Will your child be taking medication at school? No ___ Yes ___: Name, dose and reason for medication:

Note: All medication, including over-the counter (Tylenol, cough medicine etc.), is required to have a medication permission form filled out every year.

Other health info we should know?



**RIVER
FOREST
PUBLIC
SCHOOLS**

School _____
Grade _____
Teacher _____

Administration Building
7776 Lake Street
River Forest, Illinois
60305
708 • 771 • 8282
Fax 708 • 771 • 8291

MEDICATION PERMISSION FORM
MUST BE UPDATED ANNUALLY!

Student Name: _____ Birthdate: _____ Age: _____ Sex: _____
(Print)

Student Address: _____ Language at Home: _____

Is it necessary for this child to be given medication during the school day? Yes _____ No _____

(TO BE COMPLETED BY PHYSICIAN)

Name of Drug	Reason for Medication	Side Effects	Dosage	Frequency (Daily/pm)	Time to be Given at School	Start Date	End Date

____ YES This medication may be safely self-administered by the child under the supervision of the school nurse or designee.

____ NO School nurse or designee must administer medication.

Physician Signature _____

Physician Printed Name _____

Address _____ Phone _____

For Asthma Inhaler For Epi-Pen

Yes No I consent to my child's possession and unsupervised self-administration of
 Asthma medication and/or Epi-Pen

Parent's Signature _____

Physician Signature _____

Physician Printed Name _____

Address _____ Phone _____

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by a pharmacy. If it is over-the-counter medication, it will be sent in the original package with my child's name on it. I will notify the school in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication order is changed.

Parent/Guardian Signature: _____ Date: _____

Home Phone _____ Emergency Phone _____

**AGREEMENT AUTHORIZING SELF-ADMINISTRATION
OF ASTHMA MEDICATION OR EPI-PEN**

I/We, _____, the parent(s) or legal guardian(s)

of _____, a student at River Forest School District 90, hereby authorize my/our child to self-administer:

_____ Asthma Medication
_____ Epi-Pen

while at school and have provided a physician's statement in compliance with State statute. I/We have instructed my/our child not to share his/her medication with any other student. Additionally, I/We understand that according to State statute, the School District and its employees 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
_____ Epi-Pen

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
_____ Epi-Pen

by my/our child. I/We further understand that this permission for self-administration of:

_____ Asthma Medication
_____ Epi-Pen

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 _____

Signature _____

Child's School _____ Date _____