

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

2123 S. Arlington Heights Road * Arlington Heights, IL 60005 847-593-4300

HOLD HARMLESS AND INDEMNIFICATION FOR THE SELF-ADMINISTRATION OF ASTHMA MEDICATION AND/OR POSSESSION OF AN EPINEPHRINE AUTO-INJECTOR (Epi-Pen®)

This Section must be completed and signed by either: (i) the student's physician; (ii) physician assistant; or (iii) advanced practice registered nurse:

Name of Student:		
Name of Medication:		
Purpose of Medication:		
Prescribed Dosage:		
Time at which or special circumstances under which the medication is to be administered:		
Signature ó Physician, Physician Assistant or Advanced Practice Registered Nurse	Printed Name	Date
This Section must be completed	by the student's parent or	guardian.
Pursuant to the authority granted under Section hereby authorize my son/daughter,asthma medication and/or epinephrine auto-inje	, to self-administe	
I agree to indemnify and hold harmless the Schomembers, officers, employees and volunteers for reasonable attorneysø fees, suffered by any of the related directly or indirectly to my son/daught asthma medication and/or epinephrine auto-in parent or guardian of my student or another structure. We understand that the School Distribution in the structure is a result of any injury arising from those the foregoing indemnities.	rom any claim, liability, los ne foregoing indemnities and nterøs self-administration of jector (Epi-Pen®) and broudent, or by or on behalf of rict and the foregoing indivi- n the self-administration of	s or expense, including d arising out of a claim f the above referenced ught by me, any other my student or another viduals are to incur no medication, provided
Signature ó Parent/Guardian	Printed Name	Date
This form shall be effective for the current school	ol year.	

H-26 (Rev. 1/07) Distribution: health file