Germantown Hills School District #69

103 Warrior Way, Germantown Hills, IL 61548
http://ghills.metamora.k12.il.us

Mr. Dan Mair
Superintendent
Principal 3-5

Dr. Shelli Nafziger
Principal K-2

Mr. Dave Raffel
Principal 6-8

Dear Parent/Guardian:

We would like to protect the well-being of our students with special health needs. This includes assisting teachers, students, and administrators to adapt to a student's health problems.

Because of this commitment it is important that parents or guardians share certain confidential information about the student's health problem. This information will be used to plan for the care and management of the student. It will be shared with those members of the professional school staff who have direct responsibility for the student when in school or participating in school activities.

Our records indicate your child has a diagnosis of asthma. In the event your child may have an asthma attack at school, it is important for the school staff to be able to provide the best care possible for your child. It is also important to have an emergency plan in place even if your child has not had an asthma attack in several months.

The following two pages will help us with your child on a daily basis or if there is an emergency.

- **Page 1 - completed, signed and dated by you the parent/guardian**
- **Page 2 - completed, signed and dated by the child's asthma physician.**

In order for us all to stay on top of your child's health the state of Illinois requires these forms to be updated at the beginning of every school year. If there are any changes in your child's health status during the year, medications or treatments, please notify the school office so the emergency plan can be updated as needed.

If you have any questions or concerns, please contact us at 383-2121.

Yours for Better Schools,
Germantown Hills School District #69

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ASTHMA INHALER – SELF ADMINISTRATION
PARENT'S AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Name: ______________________________ Birthdate: ____________________

Address: ______________________________ Home Phone: ____________________

Father's Name: ______________________________ Cell Phone: ____________________

Mother's Name: ______________________________ Cell Phone: ____________________

Emergency Contact: ______________________________ Phone: ____________________
(Other than Parent)

Asthma Physician: ______________________________ Phone: ____________________

Primary Care Physician: ______________________________ Phone: ____________________

Preferred Hospital: ______________________________

ASTHMA TRIGGERS
Which of the following causes student's asthma attacks? (check all that apply):

_____ Exercise
_____ Respiratory Infections
_____ Temperature Changes
_____ Animals
_____ Molds

_____ Stress
_____ Strong odors/fumes
_____ Dust/Dust mites
_____ Pollens
_____ Medications

_____ Food (please list)
____
____
_____ Other (please explain)
____
____

By signing below, I agree:

- I authorize the School District and its employees and agents, to allow my child to possess and use his/her asthma medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, and/or (4) before or after normal school activities, such as while in before-school or after school care on school-operated property.
- That when the lawfully prescribed medication is self-administered, I waive any claims I might have against the School District, its employees and agents arising out of the self administration of said medication, Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self administration of medication (105 ILCS 5/22-30).
- To 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 medication by the pupil.
- That the school may contact the physician if there are problems regarding this medication.

____ **Date**: ____________________
Parent/Guardian Signature(s)

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ASTHMA INHALER – SELF ADMINISTRATION DOCTOR'S AUTHORIZATION FORM

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Student's Name: ______________________________ **Birthdate**: ____________________

Daily Medication: ______________________________ **Dosage**: ____________

Instructions for Daily Medication: ______________________________

Symptoms for use of Emergency Medication: ______________________________

____

Emergency Medication: ______________________________ **Dosage**: ____________

Instructions for Emergency Medication: ______________________________

Possible Side Effects: ______________________________

As the physician for this student, I verify that he/she has been taught proper use of his/her inhaler, has adequate knowledge of his/her asthma and how to control it, and is thought to be responsible enough to keep his/her inhaler and use it properly without supervision.

______________________________ ____________________
Physician's Signature **Date**

____
Physician's Printed Name

____
Address

____
City, State, Zip

____
Phone Number

08/2012 rmp