CAROL STREAM Park District

Self-Administration of Medication

Pursuant to Illinois Legislation, the Carol Stream Park District will permit the self-administration of medication by a participant with asthma or severe allergies with completion of this form. The Carol Stream Park District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of the medication.

Child's Name _____

FOR PHYSICIAN USE ONLY **ONE MEDICATION PER FORM**

☐ **INHALER** ☐ **EPI-PEN**

Name of Medication _____

Purpose of Medication _____

Dosage of Medication _____

Time or special circumstances under which, the medication is to be administered

_____

Physician/Provider Name *(Print)*

Address, City, State, Zip

Office & Emergency Phone Number

I have instructed the participant in proper inhaler/epi-pen administration techniques and find that the participant is able to administer the inhaler/ epi-pen- independently.

Physician/Provider Signature **Date** MM/DD/YY

Parent signature giving permission for self-administration of medication for my child:

Parent/Guardian Name *(Print)* **Phone Number**

Parent/Guardian Signature **Date** MM/DD/YY

PROGRAM SUPERVISOR USE ONLY

STAFF INITIAL _____ DATE _____