PARENTAL AUTHORIZATION AND INDEMNIFICATION FOR THE DISPENSATION OF ASTHMA INHALER MEDICINE

I, (name of parent/guardian) _____, parent or legal guardian of (name of student) _____, hereby authorize the Loyalsock Township School District and its nurses and/or designated employees to permit my child to carry and to self-administer his/her asthma medication. Prescription medicine will be accompanied by the prescribing physician's instructions.

I agree that the District and its employees are not to be held liable for allowing self-administration of asthma medicine in accordance with this Authorization. I agree to hold harmless and indemnify the Loyalsock Township School District and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action that may be brought against the District or its employees in connection with permitting self-administration. I acknowledge that the District and its employees bear no responsibility for ensuring that the medication is taken as prescribed.

This Authorization shall be effective unless revoked by me in writing. I intend to be legally bound by this Authorization. This authorization and the accompanying prescription must be renewed for each school year.

I understand that failure to adhere to the asthma policy will result in a loss of privilege to carry inhaler for the remainder of the current school year (and subsequent disciplinary action).

Signature of Parent and/or Guardian _____

Date_____

4/2022