SPRING HILL SCHOOL DISTRICT

Student Self-Administration of Medication Acknowledgement and Waiver of Liability

In order to permit my student to carry and self-administer medication which helps manage my student's asthma or anaphylaxis episodes according to a treatment plan provided by a licensed health care provider, I have read and agreed to the following terms. My signature on this form, indicates that I agree to the following requirements and waiver.

Requirements:

- I have read and understand Spring Hill School District Board of Education Policy JGFGBA – Student Self-Administration of Medications.
- I have provided the school nurse with the Food Allergy & Anaphylaxis Emergency Care Plan or the Kansas Asthma Action Plan signed by the student's Physician or other approved licensed health care professional.
- I have provided the school nurse applicable prescription information as requested by the school nurse or the Board of Education Policy JGFGBA.
- I agree that my student will demonstrate proficiency in self-administering the prescribed medication to satisfaction of the school nurse.
- I understand that I will need to attest to these requirements and complete this form on an annual basis.

Employee Immunity & Waiver of Liability

I understand and acknowledge by my signature below that the school district, its officers, employees, and agents are not liable for any damage, injury, or death resulting directly or indirectly from my student's self-administration of medication. I, on behalf of my student and myself, agree to release, indemnify, and hold the Spring Hill School District, its officers, employees, and agents harmless from and against any claims relating to my student's self-administration of medication allowed by Policy JGFGBA.

_____ _____ _____

Student Name School Grade

_____ _____

Parent Signature Date

_____

Student Signature if over 18