# PARENT REQUEST FOR SELF-ADMINISTRATION OF MEDICATION

| Name of Student | Birth Date | ID Number |
|---|---|---|
| Address | Telephone | Zip Code |

_____ has requested that my child self-administer medication
Name of Physician

Self-administration of medication during school hours. I (Mother, Father, and Legal Guardian) give permission for _____ to take medication during school hours. My physician will also submit a written statement that my child is capable of self-administering the medication at school.

***By signing this statement, I am also acknowledging that Chicago Board of Education its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the pupil. I agree to also indemnify and hold harmless the Board 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 or use of an epinephrine auto-injector by the pupil.***

_____
Signature of Parent / Guardian

_____
Address

_____
City Zip

_____
Home Phone Cell Phone Business Phone

_____
Date