HS0051
Rev. 5/19

SELF-MANAGEMENT
OF ASTHMA AND SEVERE ALLERGY (ANAPHYLAXIS) AT SCHOOL
Health Services Department
Lincoln Public Schools

PARENT/GUARDIAN: By signing below, you are acknowledging the following:

1. You are requesting that your child be allowed to self-manage his or her asthma or allergy condition at school.
2. You are affirming your confidence that your child has the knowledge and skills needed to self-manage his or her asthma or allergy safely at school.
3. You will provide an annual, written asthma or anaphylaxis care plan, accompanied by medical orders for necessary medications and treatments to the school. We request you use the LPS-provided action plans, or provide complete and equivalent information.
4. You are aware that you are not required to make this request for your child to self-manage his or her condition. Your child may continue to utilize the health office for asthma or allergy cares, and your child may request assistance at any time during the school day from qualified school health personnel in the school health office.
5. If your student injures school personnel or another student as the result of misuse of necessary asthma or allergy supplies, you shall be responsible for any and all costs associated with such injury.
6. The school and its employees and agents are not liable for any injury or death arising from a student's self-management of his or her asthma or allergy condition.
7. You will indemnify and hold harmless the school and its employees and agents against any claim arising from a student's self-management of his or her asthma or allergy.
8. These are in effect until rescinded by any party.

_____ _____
Parent/Guardian Printed Name *Student Name (printed)*

_____ _____
Parent/Guardian Signature *Date*

STUDENT: By signing below, you agree that you understand:

1. You must not share, or allow any one to handle, your medications or supplies.
2. If you need your medications, and do not receive relief when you use them, you will notify a teacher that you need assistance and/or make your way to the health office.

_____ _____
Student Signature *Date*

_____
Student Printed Name

I _____ , authorize _____
Printed Licensed Medical Provider Name

to self manage his/her asthma and/or anaphylaxis at school.

_____ _____
Licensed Medical Provider Signature *Date*