MEDICATION ADMINISTRATION/SELF-ADMINISTRATION CONSENT FORM FOR PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

Name of Student ________________________________ Date of Birth ______________
Address ________________________________ Emergency Phone ___________
School ________________________________ Grade ____________________

Part I – Physician's Statement *(This statement* ***MUST BE SIGNED BY A PHYSICIAN****, physician's assistant or advance practice registered nurse having such authority delegated by a supervising/collaborating physician* ***for APPROVED prescription medications AND all over-the-counter medications****.)*

Narcotics may not be taken prior to or during school hours.

1. Name/type of medication: ________________________________
2. Is the prescribed medication for an asthmatic condition? ____________________
3. If the prescribed medication is an epinephrine auto-injector, is the device for immediate self-administration by a person at risk of anaphylaxis? ____________________
4. Dosage/amount to be given: ________________________________
5. Route of administration: ________________________________
6. Frequency and time of administration, or special circumstances under which the medication or epinephrine auto-injector is to be administered: ____________________
7. Duration (e.g., week, month, indefinite): ____________________
8. Diagnosis, intended effect and anticipated reaction to medication (symptoms, side effects, etc.): ________________________________
9. Other medication student is receiving: ____________________
10. Other requirements or special circumstances: ____________________
11. Must this medication be administered during the school day in order to allow the student to attend school? ____________________
12. Is supervised student self-administration authorized? ____________________
13. **For asthma medication or epinephrine auto-injector only*** -- Is unsupervised self-administration authorized? ____________________

****Pursuant to Illinois law, upon parental consent, a student who is prescribed asthma medication or an epinephrine auto-injector may possess and use his/her asthma medication or epinephrine auto-injector during school or at school-sponsored activities without the supervision of district personnel.***

________________________________ ____________________
(Physician's Signature) (Date Signed)

________________________________ ____________________
(Address) (Telephone Number)

For **Antioch** students – please complete form and fax to the Nurse at ACHS: 847-838-7686
For **Lakes** students – please complete form and fax to the Nurse at LCHS: 847-838-3672

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Name of Student: ____

<u>Part II – Parental Authorization for Administration of Inhalers and Epi-pens</u> (*complete this portion only if your child uses either or both of these medications*):

I consent to my child's possession and unsupervised self-administration of asthma medication:
_____ yes _____ no

I consent to my child's possession and unsupervised use of his/her epinephrine auto-injector:
_____ yes _____ no

I acknowledge that Community High School District 117 is to incur no liability arising from the self-administration of an epinephrine auto-injector by my daughter/son. In the event my daughter/son needs assistance with administration of an epinephrine auto-injector, I understand that administration by school personnel may be performed by an individual other than a registered nurse, and I specifically consent to this. I further waive any claims against the School District, members of the Board of Education, its employees and agents arising out of the administration or self-administration of an epinephrine auto-injector, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees. With respect to administration of an epinephrine auto-injector by school personnel, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

Signed ________________________________ Phone # _______________ Date _________

<u>Part III – Parental Authorization for Medication Administration</u> (*applies to medication administration subject to district policy; at no time may students carry medication on their person with the exceptions of inhalers, epi-pens, and insulin*):

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Community High School District 117 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described in **Part I**. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Signed ________________________________ Phone # _______________ Date _________