MEDICATION ADMINISTRATION PERMISSION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

Student Name:_____ Date of Birth:_____
Address:_____
School:_____ Grade:_____ Teacher_____

I hereby confirm that my primary responsibility is to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize School District U-46 and its employees and agents, in 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 Professional Educator License (PEL) personnel and agents of the School District), lawfully prescribed medication in the manner described. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A 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 medications. In addition, I agree to hold harmless and indemnify the School District, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

*The below order must be fully completed. All medication is to be brought to school by a parent or responsible adult designee and must be in a PRESCRIPTION CONTAINER plainly marked with the student's name, medication name and dosage; including explicit directions for administration. Medication is defined as prescription, non-prescription (over the counter) drugs, and herbal preparations. Unused medication shall either be picked up by the parent/guardian or destroyed at the end of the school year. Prescription directions must coincide with the below order and be of current date. No narcotics will be given. **Please Note: Unless otherwise specified, only emergency medications will be sent on field trips and delivered under the supervision of the Professional Educator License (PEL).*

For parent(s)/guardian(s) of students who **Self-Administer Asthma Medications or may use an Epinephrine auto-Injector for Anaphylaxis, or other self-administration medications.** I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of Professional Educator Licensed personnel (PEL). Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30). Beginning fall 2010 a physician's signature is not required for Asthma Inhalers if the health office has a copy of the pharmacy labeled container for the medications(s). If you **agree** please initial: _____

My signature also gives permission to the school nurse to communicate as warranted with the undersigned physician regarding my child's medication.

Parent(s)/Guardian(s) Signature:_____Date of Signature_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Medication:_____ Dose:_____

Frequency:_____Diagnosis:_____

Effects:_____

I understand that the above medications require annual review and authorization by me. Any changes in medication or dose prior to this review require written authorization.

Physician's Signature:_____Date of Signature:_____
Physician's Printed Name:_____
Office Address:_____
Office Phone:_____Office FaxNumber:_____