



AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL BY SCHOOL PERSONNEL

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Principal's office.

STUDENT'S NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN _____ HOME PHONE _____

ADDRESS _____ GRADE/SCHOOL _____

EMERGENCY CONTACT NAME AND PHONE NUMBER: _____

I. TO BE COMPLETED BY THE PHYSICIAN

To be completed by the student's physician, physician assistant, or advanced practice nurse:

Name of Medication _____ Administration Route _____ Dosage _____

Time/Frequency/Circumstances when Medication Should be Administered _____

Student's Diagnosis _____

Possible Side Effect(s) _____

Actions to be taken if the student has side effects and/or an adverse reaction to the medication:

Intended Effects of this Medication _____

Date of Prescription _____ Discontinuation Date _____

Other medications student is receiving: _____

Is it absolutely necessary that this medication be administered in school? Yes _____ No _____

***The physician must authorize changes in dosage of any medications in writing.**

PHYSICIAN'S NAME (PRINT) PHYSICIAN'S SIGNATURE DATE PHONE

II. TO BE COMPLETED BY THE STUDENT'S PARENT OR GUARDIAN

By signing below, I, _____, parent/guardian of _____, confirm that I have reviewed and understand IPSD 204's Policy regarding the administration of medication in school. I understand that I am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize IPSD 204 and its employees and agents, on my behalf and in my stead, to administer or attempt to administer lawfully prescribed medication in the manner described above pursuant to State law. **I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.** I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the current school year and will need to be renewed each subsequent school year.

I further acknowledge and agree to waive any claims I might have against IPSD 204, its employees and agents arising out of the administration or attempted administration of said medication. In addition, I agree to hold harmless and indemnify IPSD 204, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, except a claim based on willful and wanton conduct, arising out of, incurred or resulting from the administration or attempted administration of said medication regardless of whether the authorization was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Finally, I understand and agree that it is my responsibility according to IPSD 204 policy to deliver the legally prescribed medication to the school, and pick up any remaining medication at the end of the school year from the school, myself or via another adult designee.

Parent/Guardian Signature _____ Date _____

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Principal's office.

STUDENT'S NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN _____ HOME PHONE _____

ADDRESS _____ GRADE/SCHOOL _____

I. TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

To be completed by the student's physician, physician assistant, or advanced practice nurse:

Name of Medication _____ Administration Route _____ Dosage _____

Time/Circumstances when Medication Should be Administered in School _____

Student's Diagnosis _____

Possible Side Effect(s) _____

Intended Effects of this Medication _____

Date of Prescription _____ Discontinuation Date _____

PHYSICIAN'S NAME (PRINT)

PHYSICIAN'S SIGNATURE

DATE

ADDRESS

OFFICE PHONE

PHONE – EMERGENCY

Self-Administration of Epinephrine: ____ Yes ____ No. The student listed above has a life threatening allergy that may necessitate the immediate administration of epinephrine followed by emergency medical attention. I certify that the student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. I certify that the student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: ____ Yes ____ No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to monitor and treat his/her diabetic condition during school and/or school-related activities. I certify that the student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment. I certify that the student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I certify that the student is capable of doing the following independently:

- Checking blood glucose
- Administering insulin
- Treating hypoglycemia and hyperglycemia and otherwise attending to the care and management of his or her diabetes
- Having on his or her person at all times the supplies and equipment necessary to monitor and treat diabetes (e.g., glucometers, lancets, test strips, insulin, syringes, insulin pens and needle tips, insulin pumps, infusion sets, alcohol swabs, a glucagon injection kit, glucose tablets).

II. ASTHMA MEDICATION

A written statement from the student's physician, physician assistant, dentist, optometrist, podiatrist, or advanced practice RN is not required for a student to carry and self-administer asthma medication. Parent(s)/Guardian(s) must attach the prescription label here, which must include the name of medication, the prescribed dosage, and the time at which/circumstances under which the medication is to be administered.

[Attach prescription label here]

III. SELF-CARRY OF ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR

For only parents/guardians authorizing students to carry asthma medication or an epinephrine auto-injector:

By signing below, I, _____, parent/guardian of _____, authorize IPSD 204 and its employees and agents to allow my child to carry and self-administer his or her asthma medication and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities. I hereby acknowledge that IPSD 204, its officials, employees and agents will 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 my child regardless of whether authorization was given by me or by my child's physician, physician's assistant, dentist, optometrist, podiatrist, or advanced practice register nurse. I hereby agree to indemnify and hold harmless IPSD 204, its officials, 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 my child regardless of whether authorization was given by me or by my child's physician, physician's assistant, dentist, optometrist, podiatrist, or advanced practice register nurse. (105 ILCS 5/22-30).

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

IV. TO BE COMPLETED BY THE STUDENT'S PARENT OR GUARDIAN

For all parents/guardians:

By signing below, I, _____, parent/guardian of _____, confirm that I have reviewed and understand IPSD 204's Policy regarding the self-administration of medication in school. I agree that I am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize my child to self-administer lawfully prescribed medication in the manner described above pursuant to State law, while under the supervision of the IPSD 204 employees and agents. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the current school year and will need to be renewed each subsequent school year.

I acknowledge that it may be necessary for the administration of medication 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 medication is self-administered, I waive any claims I might have against IPSD 204, its employees and agents arising out of the self-administration of said medication. In addition, I agree to hold harmless and indemnify IPSD 204, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, except a claim based on willful and wanton conduct, arising out of, incurred or resulting from the administration or self-administration of said medication regardless of whether the authorization was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Signature _____

Date _____

INFORMATION REGARDING ADMINISTRATION AND SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

A. INDIAN PRAIRIE SCHOOL DISTRICT 204 POLICY

Administering Medication to Students

Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parent/guardian believe that it is necessary for the student to take a medication during school hours or school-related activities, the parent/guardian must request that the school dispense the medication to the child and otherwise follow the District's procedures on dispensing medication.

No School District employee shall administer to any student any prescription or nonprescription medication until a properly completed and signed "Authorization for Administration of Medication in School" form is submitted by the student's parent/guardian. No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures.

Nothing in this Policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

B. PARENT RESPONSIBILITIES FOR REQUESTING ADMINISTRATION OF MEDICATION

1. The parent/guardian must provide a completed "Authorization for Administration of Medication in School" form each school year for the administration of prescription and non-prescription medications (e.g., Tylenol, Advil, cough medicine, cough drops, cold remedies, etc.). This requires written statement from a licensed health care provider and parent/guardian permission.
2. The student's parent/ guardian must obtain written orders for the administration of medication at the beginning of the school year, and whenever a change in the child's medication or health occurs, or upon request of a IPSD 204 nurse. The school must receive an updated physician's order in writing before administering a new dosage.
3. Medication must be provided in its original container labeled by the pharmacist with the student's name, medication, dosage and time to be given at school.
4. Medications must be brought to school by a parent or a designated adult and are never to be sent to school with the student. The exception to this guideline is when the student has been approved to self-administer such medication.
5. The initial dose of any medication should be given at home.
6. Medications and special items necessary to administer medications or treatments (such as syringes, feeding bags, and testing supplies) must be supplied by a parent or guardian and will be stored in an appropriate area designated by the IPSD 204 nurse or building principal.
7. Unless the child has been approved to self-administer the medication, the parent/guardian must submit a written request for the student to receive medication during a field trip or extracurricular activity to the nurse at the school or the building principal at least five (5) school days prior to the scheduled event. Administration of medication on field trips or extracurricular activities is at the discretion of IPSD 204, except as provided in a student's IEP or Section 504 plan.

INFORMATION REGARDING SELF-CARRY AND SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

Self-Carry and Self-Administration of Medication

A student may self-carry and/or self-administer an epinephrine auto-injector, medication prescribed for asthma, and/or medication prescribed for diabetes for immediate use at the student's discretion, provided the student's parent/guardian submits a properly completed and signed "Authorization for Self-Administration of Medication in School" form.

The School District shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of an epinephrine auto-injector, medication prescribed for asthma, and/or medication prescribed for diabetes or the storage of such medication by school personnel. A student's parent/guardian must indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of an epinephrine auto-injector, medication prescribed for asthma, and/or medication prescribed for diabetes, or the storage of such medication by school personnel.

C. GUIDELINES FOR SELF-CARRY AND SELF-ADMINISTRATION OF MEDICATION

1. Proper documentation (Authorization for Self-Administration of Medication in School form) must be completed before a student is allowed to self-carry and/or self-administer medications. Students are not permitted to keep medication on their person or in their lockers unless authorized to possess such medication.
2. The student who self-carries and/or self-administers medication must demonstrate consistent responsibility in:
 - A. Understanding when it is medically appropriate to take medication.
 - B. Knowing how to administer the medication and prescribed frequency.
 - C. Being familiar with expected effects and possible side effects of the medication.
 - D. Understanding that medication is not to be shared with anyone.
 - E. Seeking additional help from the teacher, nurse or other school personnel if symptoms persist or if student is experiencing side effects after administering a medication.
 - F. The student will only carry a **one day supply** of medication on his/her person.
3. The student's name must be marked on the medication.
4. The school will not keep a record of the student's self-administration of medication unless determined necessary by the student's IEP or Section 504 team.
5. Students will be allowed to self-administer approved medication during the school day, at school sponsored activities, and at before or after school activities.
6. The self-administration of asthma inhalers does not require a physician's order if the parent/guardian provides the **student's prescription label from the pharmaceutical box**, which must contain the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered, and completes the Authorization for Self-Administration of Medication in School form.
7. If a student self-administers epinephrine, the student must notify a teacher/nurse/school staff member immediately. EMS (911) will be called when epinephrine is administered.
8. The privilege to self-carry and self-administer medication will be revoked for safety reasons if the student does not demonstrate appropriate responsibility.
9. IPSD 204 is committed to supporting capable students, assuming appropriate parental and medical authorization is provided, in becoming independent in their ability to self-administer medication to treat their medical condition.