COMMUNITY HIGH SCHOOL DISTRICT 218

CHSD 218

Dwight D. Eisenhower • Harold L. Richards • Alan B. Shepard • Delta • Summit

## Physician Authorization and Permission for Self-Administration of Medication

Student's Name (Last) (First) (Middle) | Date of Birth | Building | Date

School medications and health care services are administered following these guidelines:

- Physician/Prescriber signed and dated authorization to administer the medication.
- Parent signed and dated the authorization to administer the medication.
- The medication is in the original labeled container as dispensed to the manufacturer's labeled container.
- The medication label contains the student's name, name of medication, directions for use and date.
- Annual Renewal of authorization and immediate notification, in writing, of changes.

**Physician Authorization:**

Medication/Health Care Treatment | Dosage | Time to be Administered

Reason for and intended effect of this medication

Expected side effects, if any

Other medications student is taking/are there possible other potential drug interactions

May student self-administer medication under supervision of Health Service personnel or designate? YES NO

Administration Instructions

Date of Prescription | Date of Order | Discontinuation Date

Diagnosis and time period for re-evaluation of student's medication need/dosage

Maintenance Requirements, if any (e.g. refrigeration, sunlight exposure, etc.)

Prescriber's Signature | Date

Prescriber's Emergency Phone # | Prescriber's Address

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## Parent/Guardian Authorization of Self-Medication Administration

Student Name: _____

Date of Birth: _____

Parent(s)/Guardian(s) Name(s): _____

Address: _____

Home #: _____ Business #: _____ Cell #: _____

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 218 and its employees and agents, on my behalf and stead, to administer to my child (or allow my child to self-administer while under the supervision of the employees and agents of the School District, and have in their possession their prescribed inhaler and/or Epi-Pen) lawfully prescribed medication in the manner described above. 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, consistent with the law, and specifically consent to such practices, under Illinois Law 105 ILCS 5/22-30. 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 such medication.
The school recommends that the parent provides an extra device, equipment or medication to be kept in the Nurse's Office.

Parent Signature: _____ Date: _____

Additional Information:

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