Downers Grove Grade School District 58

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

(To be completed annually by physician and parent. This document is only valid through the end of the current school year)

Student's Name____ Birthdate:___________________

Name of School: ____ Grade/Teacher: ______________

This child is under my medical care for _________________________________ and medication is **required** during the school day.
(Diagnosis)

Name of Drug	Dosage	Route	Frequency	Time to be given at school	Possible Side Effects

Additional Instructions:
____
____

Medication shall be administered from ________________ to ________________ Remainder of school year
Date Date

Other medication student is taking ____

Prescriber's name/Title: ____

Phone: _________________________________Fax: __________________________

Prescriber's signature: ____

Date: _______________________

OFFICE STAMP

(To Be Completed By Parent or Legal Guardian)

I give permission for my student to receive the above medication(s) as directed by the physician. I will bring the medication to the school nurse in a container labeled by the pharmacy or in original packaging. I will provide a written doctor's order if the medication dosage is changed or the medication is discontinued. For all medications other than self-administered asthma medications or epinephrine auto-injections, I understand that it is the responsibility of the student to report to the District 58 Health Office at the scheduled time to receive the medication. I further completely release, excuse, and hold harmless Downers Grove Grade School District 58 and its employees and agents, heirs, and assigns of any liability claim, or obligation of any nature in any way related to the District's medication policy and procedure and the administration of medication to my student. I further 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.

Parent Signature: ______________________________________ Date: ________________________

Daytime Phone: ________________________________

Emergency Contact (other than parent): ____

Contact phone: ___________________________ Relationship to child: ___________________________________

SELF-ADMINISTRATION OF ASTHMA OR EPIEPHRINE MEDICATION

"Self-administration" refers to a student's discretionary use of his or her prescribed **asthma** medication or **epinephrine auto -injector (self- administration for these purposes does not include the self-administration of any other medications).** Therefore, as the parent/guardian, I acknowledge that the student is responsible
for having asthma medication or an epinephrine auto-injector available as needed, and that the student has demonstrated competency in the proper way to use the medication.

acknowledge that, District 58, along with its employees and agents, including the student's physician, physician assistant, or advanced practice nurse providing standing protocol or a prescription for school epinephrine auto-injectors incurs no liability, or professional discipline, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of asthma medication or epinephrine auto-injector regardless of whether authorization was given by the student's parents or guardians or by the student's physician, physician assistant, or advanced practice nurse. I forever free, indemnify, excuse, and hold harmless District 58, along with its employees, agents, heirs, and assigns, against any claims (except a claim based upon willful and wanton conduct), including claims for professional discipline, as a result of any injury or other claim arising from the administration of asthma medication or of an epinephrine auto-injector regardless of whether authorization was given by the student's parents or guardians or by the student's physician, physician assistant, or advanced practice nurse.

Epinephrine Auto-injector (Please initial)

__________Please allow my child to carry and self-administer his/her epinephrine auto-injector medication during the school day and at school events

Or

__________Please store my child's epinephrine auto-injector medication in a designated location during the school day and at school events.

Asthma Inhalers (Please initial)

__________Please allow my child to carry and self-administer his/her asthma medication during the school day and at school events *(Please attach prescription label to back of this form if self-administering)*

Or

__________Please store my child's asthma medication in the school health office where my child can access the medication as needed.

Parent Signature: ______________________________________ Date: _______________________

Daytime Phone: ________________________________

Emergency Contact (other than parent): ____

Contact phone: ___________________________ Relationship to child: __________________________________

Revised 03/2020