INDIAN PRAIRIE SCHOOL DISTRICT 204

# 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]

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## 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_____