KILDEER COUNTRYSIDE COMMUNITY CONSOLIDATED SCHOOL DISTRICT 96
SCHOOL MEDICATION AUTHORIZATION FORM
Physician's Order

Student Name_____ **Grade/Teacher**_____

Medication_____ **Dosage/Route**_____

Time to be given_____ **Start date**_____ **End date**_____

Reason for medication _____**Possible side effects**_____

_____ _____

Physician's name (print) **phone #** **Physician's signature** **date**

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I,_____, parent or guardian of _____ 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 Kildeer Countryside Community Consolidated School District 96, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of District 96, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. 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 _____ school year and will need to be renewed each subsequent school year.**

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Kildeer Countryside Community Consolidated School District 96, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless Kildeer Countryside Community Consolidated School District 96, 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, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication 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: _____

Procedures and Guidelines

1) No school personnel shall administer to any student, nor shall any student possess or consume any prescription or non-prescription medication except after filing completed Medication Authorization information. This authorization shall include: licensed prescriber's written prescription with child's name, medication name and dosage, and date of order, administration instructions with route, time or intervals, duration of prescription, intended effects and possible side effects and parent written permission.
2) Appropriate containers: Medications and refills are to be in containers that are prescription labeled by a pharmacy or licensed prescriber to display Rx number, student name, medication, dosage, directions for administration, date and refill schedule, pharmacy label and name/initials of pharmacist or the manufacturer's label for non-prescription over the counter medications.
3) Medication will be administered by the certified school nurse, registered school nurse, school administrators, their designees and agents. The school nurse or administration retains the discretion to deny requests for administration of medication.
4) Medication, except for epinephrine, will be stored in a locked cabinet. Those requiring refrigeration will be in a secure area. Each dose will be recorded in the individual student's health record. In the event a dose is not administered, the reason shall be enetered in the record. The parent may be notified if indicated. To assist in the safe monitoring of side effects or intended effects of the treatment with medication, faculty and staff may be informed regarding the medication plan.
5) To facilitate needed documentation, physician's orders, any changes in the orders, and parent permissions may be faxed to your child's school. It is the parent's responsibility to assure that all physician orders and permissions are brought to school and refills provided when needed and to inform the school nurse of any significant changes in the student's health.
6) Medications remaining at the end of the year will be destroyed unless picked up by the parent.
7) For the safety of all, medication must be brought to the school by the parent or other responsible adult.

FOR STUDENT SELF-ADMINISTERING **EPINEPHRINE OR DIABETES** MEDICATION ONLY

TO BE COMPLETED BY THE STUDENT'S **LICENSED PRESCRIBER** and cosigned by the student's parent/guardian

Student Name_____Grade/Teacher_____

Diagnosis _____ Name of Medication_____

Dosage: _____ Route _____

Time/Circumstances when medication should be administered_____

Possible side effects_____

Date of Rx_____ Discontinuation date_____

Self-Administration of Epinephrine: The student listed above has a life threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. 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: The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

_____ _____

Physician's Name (Print) phone # Signature of Physician Date

_____

Parent/Guardian Signature Date

PERMISSION FOR STUDENT TO SELF-ADMINISTER **ASTHMA** MEDICATION ONLY

TO BE COMPLETED BY THE STUDENT'S **PARENT/GUARDIAN**

Student Name_____Grade/Teacher_____

Name of Medication _____ Dosage _____

Time/Circumstances when medication should be administered_____

Possible side effects_____

Date of Rx_____ Discontinuation date_____

Self-Administration of Asthma Medication: My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. When able to, I will provide the school with an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Signature: _____ Date: _____