School Medication/Self-Administration Authorization Form

To be completed by Parents/Guardian

Student _____ Birth Date _____

Address _____ Home Phone No. _____

School _____ Grade _____

Emergency Phone No. _____ Cell Phone/Pager No. _____

Is it vital that your child takes this medication on field trips? (*Check one*) ( ) Yes ( ) No

As the legal Parent/Guardian of _____
Student's Name

I hereby request and grant permission for Community Consolidated School District 89 personnel to administer medication to my daughter/son according to the instructions from the physician given below. I understand that administration by school personnel may be performed by an individual other than a certificated and/or registered nurse, and I specifically consent to this. I further waive any claims against School District 89, members of the Board of Education, its employees, and agents arising out of the administration or self-administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes or action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication. With respect to student self-administration of asthma medication and/or epinephrine auto-injector, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

_____ _____ _____
Parent/Guardian Signature Phone Number Date

FOR ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR ONLY:
I give permission for my child to carry his/her inhaler and/or epinephrine auto-injector and be responsible in its use, provided the doctor gives consent for the same.
(*Check one*) ( ) Yes ( ) No

To be completed by the student's Physician

Student's Name _____ Medication _____

Reason for medication: condition/illness _____

Dosage _____ Frequency _____

Route of administration _____ Time to be given during the school day _____

Common side effects _____

Other medications student is receiving _____

FOR ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR ONLY: The above named student may carry and self-administer his/her inhaler and/or epinephrine auto-injector. I certify that she/he has been properly instructed in its use. (*Check one*) Yes No

_____ _____
Physician's Signature Physician's Name (Please print)

_____ _____ _____
Physician's Address Date of Signature Physician Phone No.

Reviewed 1/11, 5/14, 3/17, 7/20, 5/24

Arbor View Elementary School Phone (630) 469-5505 Fax (630) 469-1455
Briar Glen Elementary School Phone (630) 545-3300 Fax (630) 469-1455
Glen Crest Middle School Phone (630) 469-5220 Fax (630) 469-1455
Park View Elementary School Phone (630) 858-1600 Fax (630) 469-1455
Westfield Elementary School Phone (630) 858-2770 Fax (630) 469-1455