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 ______________________________ Birth Date: ______________________

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	Side effects & Intended Effect

Additional Instructions:

____

____

____

____

Date Medication Administration Should Be Discontinued / Re-Evaluated (circle one): ______________________

Other medication student is taking: ______________ ______________

OFFICE STAMP

Signature of Physician ______________________ **Date**______________

Printed Name of Physician ______________________ Physician's Office and Emergency Phone # ______________

(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. 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-injectors, 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.

"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.

I, ______________________, the parent/guardian of the above student 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 and date ______________________________ **Telephone** ______________ / ______________
Home Work or Cell

Emergency contact ______________________________ **Contact telephone** ______________________