COMMUNITY HIGH SCHOOL DISTRICT #94
HEALTH SERVICES

PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Phone: (630) 876-6245
Fax: (630) 876-6585

THIS FORM IS REQUIRED IF YOUR CHILD IS TO RECEIVE NON-PRESCRIPTION AND/OR PRESCRIPTION MEDICATION AT SCHOOL.

STUDENT NAME:_____
(Last) (First) (Middle)

DOB:_____ ID#:_____

The following guidelines shall apply to the self-administration of a student's asthma or severe allergy medication (Epi-Pen):

- An Illinois physician/prescriber signed and dated authorization to administer the medication, setting forth the name and purpose of the medication, the prescribed dosage, time for administration, and any other special related information with regard to the administration of stated medication must be on file in the Health Office.
- Parent (Guardian) signed and dated authorization to administer the medication must be on file in the Health Office.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student's name, name of medication, directions for use and date.
- Annual renewal (with the start of each new school year) of authorization and immediate notification, in writing by the prescribing physician, of changes.
- It is recommended that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her asthma or severe allergy medication (Epi-Pen).
- The school district and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

PARENTAL AUTHORIZATION:

I hereby acknowledge that I am the parent/legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize Community High School District #94 to allow my child to self-administer his/her lawfully prescribed asthma or severe allergy medication (Epi-Pen) during the following: 1) while in school; 2) while at a school sponsored activity; 3) while under the supervision of school personnel; and 4) before or after school activities.

I further acknowledge and agree that Community High School District #94 and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma or severe allergy medication (Epi-Pen). I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the school district and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self administration of said medication. In addition, I agree to indemnify and hold harmless the school district and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self administration of said medication.

If the medication prescribed is to be self-administered by the student, I authorize and give permission for my child, _____ to carry and self-administer the asthma or severe allergy medication(s) described on
(Name of Student)
the previous page. I, or my child's physician, will notify Community High School District #94 of changes in asthma or severe allergy medication or in my child's condition.

SIGNATURE:_____ _____
(Parent/Guardian) (Home Phone)

DATE:_____ _____
(Business Phone)

Reference: Illinois Department of Human Services and Illinois State Board of Education
"Recommended Guidelines for Medication Administration in Schools"
Asthma Management: A Resource Manual for Schools