CCSD93
Maximizing the academic, social & emotional potential of each student

# Medication Administration Permission Form

Student Name: _____ Date of Birth: _____
Address: _____
School Name: _____ Grade: _____ Teacher: _____

As the parent/guardian, I understand that it is district policy that medication should not be administered to a student at school, or when involved in school activities, unless medication is critical to the health and well-being of a student. Medication administered at school would be given by the certified school nurse, registered nurse, staff member delegated by the nurse, an administrator, or if appropriate, the student may self-administer during school hours. This policy is in line with Illinois Public Act 91-719 and the Illinois Nurse Practice Act 2018. I waive any claims against CCSD93, its Board of Education, and individual members thereof, and its employees arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify CCSD93, its employees and agents, either jointly or severally, from any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

**I understand that medication must be brought to the school by myself or an adult designee, in the original container, labeled with the student's name, physician's name, medication name and dose, and explicit directions for administration.**

I understand that my child will be assisted in taking the medication(s) described below by authorized persons or be permitted to medicate himself/herself as authorized below by my child's physician and myself. I further consent to the sharing of relevant medical information related to this medication between the school and physician's office.

_____

**Parent/Guardian signature** **Best phone number to call** **Date**

**For parent/guardian of student who will self-carry albuterol or epinephrine:**

I authorize the CCSD93 and its employees to allow my child/ward to self-carry and administer his/her emergency medication while at school, at school sponsored activities (both on and off campus), under the supervision of school employees and agents. Illinois law requires CCSD93 to notify parents/guardians that it, and its employees and agents, will incur no liability for any injury arising from a student's self-administration of medication (105ILCS 5/22-30), except for willful and wanton misconduct.

A physician and parent/guardian signatures are required for a student to self-carry an epinephrine auto-injector.

Only a parent/guardian signature is required for a student to self-carry an albuterol inhaler.

The Nurse's Office must have a current copy of the pharmacy label for self-carry medication. **Please initial:** _____

Nurse initials/date: _____

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Student Name: _____

**Provider to complete page 2**

1. Must this medication be administered during the school day in order to address the student's medical condition that may arise in school? YES / NO

Medication Name: _____ Dose: _____

Purpose/Diagnosis: _____ Frequency: _____

Effects: _____

Additional instructions: _____

**Is the student able to self-carry/self-administer medication (Epinephrine only)?** YES / NO

_____

**Physician Signature/Printed name** **Date**

_____

**Office address** **Office phone number** **Office fax number**

2.Must this medication be administered during the school day in order to address the student's medical condition that may arise in school? YES / NO

Medication Name: _____ Dose: _____

Purpose/Diagnosis: _____ Frequency: _____

Effects: _____

Additional instructions: _____

**Is the student able to self-carry/self-administer medication (Epinephrine only)?** YES / NO

_____

**Physician Signature/Printed name** **Date**

_____

**Office address** **Office phone number** **Office fax number**

3.Must this medication be administered during the school day in order to address the student's medical condition that may arise in school? YES / NO

Medication Name: _____ Dose: _____

Purpose/Diagnosis: _____ Frequency: _____

Effects: _____

Additional instructions: _____

**Is the student able to self-carry/self-administer medication (Epinephrine only)?** YES / NO

_____

**Physician Signature/Printed name** **Date**

_____

**Office address** **Office phone number** **Office fax number**

Nurse initials/date: _____

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Nurse initials/date: _____

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