Potomac CUSD #10

Administration of Medicine
Permission For Administering Medication

Name of Student _____ Birthdate_____

Address _____ Phone _____

_____

School _____ Grade _____ Teacher _____

Part I - Physician's Statement

1. Name/type of medication _____
2. Dosage/amount to be given _____
3. Frequency/times to be administered _____
4. Duration (week, month, indefinite, etc. _____
5. Anticipated reation to medication _____

_____

_____

_____ _____

Signature of Physician Date Signed

_____ _____

Address Phone Number

Part II - Parent's Consent and Waiver of Liability

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the school district and its employees and agent, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the school district), medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medications. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action, or injuries incurred or resulting from the adminstration or attempts at administration of said medication.

_____ _____

Parent/Guardian Signature Date

To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office:

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

To be completed by the student's physician:

Physician's Printed Name:		
Office Address:		
Office Phone:	Emergency Phone:	
Medication:		
Dosage:	Frequency:	
Time medication is to be administered or under what circumstances:		
Prescription date:	Order date:	Discontinuation date:
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? ☐ Yes ☐ No		
Expected side effects, if any:		
Time interval for re-evaluation:		
Other medications student is receiving:		

_____ _____

Physician's signature Date

For parent(s)/guardian(s) of students who have asthma:

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

If you agree please initial: _____

Parent(s)/Guardian(s) initial

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. **I 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**, and
2. To indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

_____	_____
Parent/Guardian printed name	Parent/Guardian printed name
_____	_____
Parent/Guardian signature* Date	Parent/Guardian signature* Date

* *Both parents and/or guardians, if available, should sign.*