

PLAINFIELD DISTRICT 202 MEDICATION AUTHORIZATION FORM

When a child requires medication, the primary responsibility for administering such medication rests solely upon the parents. The district recognizes that some short and long term conditions can be controlled or corrected only when medicated at intervals which may include school hours. In those instances when the doctor has determined that administration during school hours is necessary for optimum benefits, the school district endorses the following procedures:

1. Medications are defined as OVER-THE-COUNTER AND REGISTERED-PRESCRIPTION DRUGS . Only medication necessary to maintain a child in school shall be administered during the school day.
2. The physician will complete the Order for Medication (see below).
3. The parent will complete the Parent's Request to Administer Medication (see below).
4. Medication will be in the original container or prescription bottle appropriately labeled by the pharmacist, physician or manufacturer.
5. Medication will be stored in school in a safe place.
6. Only a certified school nurse, a registered nurse, or a certified administrator shall administer medications; however, any employee who is willing to do so may supervise the self-administration of medications.
7. Any certified employee may administer medications in emergency situations if, under the circumstances, the school nurse, a certified administrator or emergency medical personnel cannot be available in sufficient time and the student cannot reasonably self-administer the medication.
8. Unless otherwise authorized by administration and/or school nurse, no student is to be in possession of any medication upon the start of the school day.

In consideration, therefore, the undersigned releases Plainfield District 202, its Board, Agents, and Employees from all claims that may arise as a result of action or inaction resulting from the request herein made. It is understood that the parent or guardian(s) accept full responsibility for the giving of medication.

Students Name _____ Birth Date _____ Grade _____

LICENSED PRESCRIBER'S ORDER FOR MEDICATION

I have determined that the following medication must be taken during school hours.

Drug _____

Dosage _____ Time Given _____

Method _____

Side effects _____

Emergency Conditions _____

Diagnosis _____

Medication beginning date _____

Medication ending date _____

(In case of an emergency relating to the medication given at school, include the physician's telephone number.)

Physician's Signature _____ Phone Number _____

PARENT'S REQUEST TO ADMINISTER MEDICATION

I hereby request that Plainfield District 202 administer the drug ordered by

Dr. _____ to my child during school hours.

Time: _____

Prescription Number _____

Pharmacy: _____

I can be reached at the following telephone number(s) in case there is a problem or a question _____.

Parent / Guardian Signature _____ Date _____

Home Phone: _____

Work Phone: _____

Emergency Phone: _____

PLAINFIELD COMMUNITY CONSOLIDATED SCHOOLS

ASTHMA OR EMERGENCY MEDICATION AUTHORIZATION
HOLD HARMLESS AND INDEMNITY

This Section must be completed and signed by either: (i) the student's physician; (ii) physician assistant; or (iii) advanced practice registered nurse:

Name of Student: _____

Name of Medication: _____

Purpose of Medication: _____

Prescribed Dosage: _____

Time at which or special
circumstances under which the
medication is to be administered: _____

Signature of physician, physician's assistant or
advanced practice registered nurse

Date

This Section must be completed by the student's parent or guardian:

Pursuant to the authority granted under Section 105 ILCS 5/22-30 of the Illinois School Code, I hereby authorize my son/daughter, _____, to self-administer the above-referenced asthma or emergency medication.

I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees and volunteers from any claim, liability, loss or expense, including reasonable attorney's fees, suffered by any of the foregoing indemnities and arising out of a claim related directly or indirectly to my son/daughter's self-administration of the above referenced asthma or emergency medication of and brought by me, any other parent or guardian of my student or another student, or by or on behalf of my student or another student. We understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the self-administration of medication, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnities.

Parent/Guardian

Date

This form shall be effective for one school year.