WILLOWBROOK HIGH SCHOOL DISTRICT #88
HEALTH SERVICES

Phone 630-530-3458 **Fax 630-530-6062**

Authorization for the Administration of Medication in School

(To be completed by physician)

Student _____Grade 9 10 11 12
ID #_____

Medication _____

Dosage _____Frequency_____

Diagnosis_____

Possible Side Effects _____

Specific Concerns _____

All medication administered in school must be in the original container properly labeled from the pharmacy

Physician's Name _____

Phone # _____
Address _____

Physician's Signature _____

Date _____

Authorization for the Self-Administration of Epinephrine or Rescue Asthma Medication

(To be completed by physician)

Student _____Grade 9 10 11 12
ID #_____

Medication_____

Dosage _____Frequency_____

Diagnosis _____

Possible Side Effects _____

Specific Concerns _____

I certify that the above named patient has been instructed in the use and self-administration of the above listed medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Physician's Name _____

Phone # _____
Address _____

Physician's Signature _____

Date _____

This form shall be effective for one school year and must be renewed each year.

1/09

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HEALTH SERVICES

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Parental Authorization for the Administration of Medication in the School

All medication should be administered at home when possible. However, if your physician decides that it is necessary to take medication during the school day, a *medicine authorization form* must be provided to school personnel. Students are prohibited from carrying medications or keeping medications in their lockers. Only students authorized to self-administer asthma and/or epinephrine medications, pursuant to the regulations on self-administration of asthma and epinephrine medications in school, are permitted to carry those medications on themselves.

The first dose of medication must be given (administered) at home. Medications should be brought to school in the properly labeled container from the pharmacy. The label should include the students name, medication, and dosage. Over-the-counter medications (also requiring authorization by a physician), must have the original container/box labeled by the manufacturer with students name clearly marked on the container.

TO BE COMPLETED AND SIGNED BY THE STUDENT'S PARENTS/GUARDIAN.

I hereby request and grant permission for DuPage High School District #88 school personnel to administer or supervise the administration of medication to my son/daughter, _____, according to the instructions provided by the prescribing physician. I agree to permit the school personnel to contact the physician regarding any questions about the medication administration or medical condition. I further agree to indemnify and hold harmless School District #88, DuPage County, Illinois, its Board of Education members, employees, agents, attorneys, representatives, volunteers, and successors are to incur no liability including but not limited to; actions, causes of actions, any and all damages, debts, claims, obligations, personal injuries, including death, disabilities, medical expenses, attorneys' fees or other demands, except for those due to the School District's willful and wanton conduct, as a result of any injury arising from the administration of medication.

_____ _____
Signature of Parent or Guardian Date

For the Self-Administration of Epinephrine or Rescue Asthma Medications

I, _____, as the parent or legal guardian of _____, a student at DuPage High School District # 88, hereby authorize my child to self-administer asthma medication or use an epinephrine auto-injector. I understand that giving my authorization, my child may possess and use asthma medication or an epinephrine auto-injector while in school, while under the supervision of school personnel, or before or after school activities, such as while in before-school or after-school care on school property. I must provide School District #88 with an authorization from the physician containing name, dosage, frequency, diagnosis, possible side effects, and any special considerations. 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 fee's 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 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.

_____ _____
Signature or Parent or Guardian Date

This form shall be effective for one school year and must be renewed each year.

1/09