COMMUNITY CONSOLIDATED SCHOOL DISTRICT # 46
PARENTAL AUTHORIZATION SELF-ADMINISTRATION OF MEDICATION

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

BIRTH DATE: _____

SCHOOL: _____

DATE: _____

The following guidelines shall apply to the self-administration of a student's medication:

Physician/Prescriber signed, 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 to the administration.

Parent (Guardian) signed, dated authorization to administer the medication.

The medication is in the original labeled container as dispensed or the manufacturer's labeled container.

The medication label contains the student name, name of medication, directions for use and date.

Annual renewal of authorization and immediate notification, in writing, of changes.

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 and/or 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 School District #46 to allow my child to self-administer his or her lawfully prescribed medication 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 normal school activities.

I further acknowledge and agree that the School District 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 medication. 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.

Parent Signature:_____

Date:_____

Home Phone: _____ Cell Phone:_____

COMMUNITY CONSOLIDATED SCHOOL DISTRICT # 46

PHYSICIAN AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION

_____ _____
Student Name Birth Date

_____
Address

_____ _____
Emergency Contact Person Emergency Contact Cell Phone Number_

TO: PRINCIPAL: _____

SCHOOL: _____

The above named pupil has _____
(Name of Condition)

I am requesting that the above named student take the following medication as prescribed below during school hours (including before or after normal school activities, while in a school-sponsored activity and while under the supervision of school personnel):

_____
Name of Medication

_____
Purpose of Medication

_____
Dosage Time(s) to be Administered

_____
Special Circumstance Under Which Medication is to be Administered

_____
Possible Side Effects

I certify that _____ has been instructed in the use and
(Name of Student)

self-administration of _____.
(Name of 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.

_____ _____
Prescribers Signature Date Signed

_____ _____
Print Name of Prescriber Prescriber's Emergency Phone #