ELMHURST
COMMUNITY UNIT SCHOOL DISTRICT 205

To: Parents

From: District Nurses

Re: Self-Administration of Medication by Students at School

It is the policy of Elmhurst Community Unit School District 205 that the administration of medication, including self-administration of medication, during regular school hours should be discouraged unless necessary to maintain the student in school, or in the event of an emergency. If medication needs to be self-administered at school, the following requirements must all be met. These requirements apply to both prescription and non-prescription (over the counter) medication.

1. All prescription medication must be brought to the school in its original pharmaceutical container, clearly marked with the child's name, the name of the medication, directions for use, and date. Duplicate prescription bottles can be obtained from your pharmacist.
2. All non-prescription (over the counter) medication must be brought in the manufacturer's original, unopened container, and must be clearly marked with the child's name, the name of the medication, directions for use, and date.
3. Both the student's parent and physician/prescriber must complete, sign and date the authorization to self-administer medication. Please return a completed MEDICATION AUTHORIZATION FORM FOR SELF-ADMINISTRATION OF MEDICATION to the District by mail or fax.
4. The parent and physician/prescriber must report immediately any change in prescription or dosage by completing a new authorization form for each change.
5. Medication should be brought to the school office by the parent. At the end of the year, the medication should also be picked up by the parent. The District must receive a new authorization form each year for continued administration of medication.

If you should have any questions regarding this medication policy, please call your school nurse. Thank you for your cooperation in this matter.

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MEDICATION AUTHORIZATION FORM
FOR SELF ADMINISTRATION OF MEDICATION

Student's Name (Last) (First) (Middle Initial) Birthday School Date

Pursuant to District policy, students may self-administer medication (prescription or non-prescription) *only if the District has received this form, which must be completed, signed, and dated by both a licensed prescriber and the student's parent or guardian. Medication must also be brought to the school in containers that comply with District policy.* Parents must immediately notify the District of any changes required for administration of medication by completing a new copy of this form and returning it signed and dated by both the parent(s) and a licensed prescriber. A new copy of this form must be completed at the beginning of each new school year for continued self-administration of medication. Please see the District's medication policy for a full description of the District's medication guidelines.

To be completed by a Licensed Prescriber (e.g., physician)

Diagnosis requiring self-administration of medication: _____
Name of medication: _____ Dosage: _____
Administration route or other directions: _____
Frequency: _____Time(s) to be self-administered:_____
Intended effect of medication:_____
Side effects anticipated? ( ) No ( ) Yes, please describe:_____

_____ _____
Start of Administration Discontinue/re-evaluate/follow-up date (circle one)

I, the undersigned, am requesting that the above-named student be allowed to self-administer the above-named medication, in the dosage and at the times indicated, during school hours. I certify that the above-named student has been instructed in the use and self-administration of the above-named medication. The student understands the need for the medication, and the necessity to report to school personnel any unusual side effects. The student is capable of using this medication independently.

PHYSICIAN'S NAME (print) _____

ADDRESS_____

PHYSICIAN'S SIGNATURE_____DATE_____

To contact me in the event of a reaction to the medication or in an emergency:

PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

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To be completed by the Parent or Guardian:

I understand and acknowledge that I am primarily responsible for administering medication to my child. Because self-administration of medication by my student is necessary to maintain the student in school, or may be necessary in the event of an emergency, I give permission for my student to self-administer the above medication in the manner described above, while under the supervision of school personnel.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I or my student might have against the School District, the Board of Education and its members, and District employees, officers, agents, and volunteers from any claim, liability, loss, or expense, including legal fees, reasonable attorney's fees, and medical fees, related directly or indirectly to the self-administration of said medication by my student. In addition I agree to hold harmless and indemnify the School District, the Board of Education and its members, and District employees, officers, agents, and volunteers, jointly or severally, from and against any and all claims, damages, causes of action or injuries brought by or on behalf of any party that is related directly or indirectly to the self-administration of said medication.

PRINTED NAME:_____ RELATIONSHIP:_____

SIGNATURE:_____DATE:_____

To contact me in the event of a reaction to the medication or in an emergency:

PHONE NUMBER:_____ ALTERNATE PHONE NUMBER:_____

8/12/2011