Elmhurst Community School District #205
Physician Order and Parental Authorization for Medication Administration

Student Name: _____ **Date of Birth**_____
School: _____ **School Year:** _____ **Grade:** _____

To Be Completed by the Physician:

Only medications that are prescribed by a physician and are essential to maintain a student while at school shall be given. Please indicate whether this medication must be taken during the school day:
Yes _____ **No** _____
Diagnosis requiring medication during the school day:_____

Name of medication: _____

Dosage to be administered:_____ Administration route/directions:_____

Frequency: _____ Time(s) to be administered:_____

Intended effect of medication:_____

Possible side effects:_____

Start Date of Order:_____Discontinue/reevaluate/follow-up date:__

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If the physician is prescribing allergy, asthma or diabetes medication, **THE PHYSICIAN** must complete the following section for the type of medication being prescribed, in addition to the signature portion of the form.

SELF CARRY/SELF ADMINISTRATION OF EPINEPHRINE: _____ **Yes** _____ **No**
The student has been instructed in the self administration of the medication listed above and is capable of administering the medication independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self administration of the epinephrine auto-injector.

SELF-CARRY/SELF ADMINISTRATION OF DIABETIC MEDICATION: _____ **Yes** _____ **No** The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for the child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Medical Management Plan. The student has been instructed in the self administration of the medication listed above and use of his/her diabetic supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

SELF CARRY/SELF ADMINISTRATION OF ASTHMA MEDICATION: _____ **Yes** _____ **No** The student listed above has been diagnosed with asthma. The student has been instructed in the self administration of the medication and is capable of administering the medication independently. The student understands the need for the medication and the necessity of notifying a staff member and health office personnel in the event that the medication is not remedying the student's symptoms of asthma or in the event of unusual side effects.

Physician's Name(print) _____ Physician's Signature: _____
Date: _____ Address:_____
Phone Office: _____ Emergency Phone : _____

cont. pg 2)

Student: _____ Date of Birth: _____
Name of Medication: _____

To be completed by the student's Parent/Guardian <u>ONLY</u> for Student Self Carry/Self Administration of Asthma Medication (a copy of the inhaler prescription box must accompany this form if prescription above is not completed by a physician). My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified healthcare professional. I hereby authorize my child to self-carry and self-administer his/her asthma medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel if the medication is not effectively treating his/her asthma symptoms or of any unusual side effects.

Parent/Guardian Signature: _____ **Date:** _____

<u>STATEMENT BELOW MUST BE SIGNED BY PARENT/GUARDIAN FOR MEDICATION AUTHORIZATION TO BE COMPLETE :</u>

I understand and acknowledge that I am primarily responsible for administering medication to my child. Because administration/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 to district personnel to administer or if authorized by their physician 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 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.

Pursuant to District policy, medication (prescription or non-prescription) may be administered to students 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 delivered 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 administration of medication. Please see the District's medication policy for a full description of the District's medication guidelines.

PRINTED NAME: _____ Relationship to Student:_____
Signature: _____ Date_____

To contact me in the event of a reaction to the medication or in an emergency:
Phone Number: _____ Alternate Phone Number: _____

2/2017