West Aurora School District 129
WEST AURORA • NORTH AURORA • MONTGOMERY • SUGAR GROVE • BATAVIA

District Administration Office
1877 W. Downer Place
Aurora, IL 60506

Phone: 630.301.5000
Fax: 630.844.4442
www.sd129.org

AUTHORIZATION FOR STUDENT SELF-ADMINISTRATION OF EPINEPHRINE MEDICATION

STUDENT'S NAME: _____ GRADE: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: _____

I _____ parent/guardian of _____ state that my child h been diagnosed with a life threatening allergy and has been prescribed epinephrine medication by a qualified heal care professional. I hereby authorize my child to carry the following medication and to self-administer his/h medication as prescribed by his/her physician. My child understands the need for the medication and the necessity reporting to school personnel any unusual side effects. I will notify the school of changes in the medication changes in my child's condition. I have provided the school with a copy of my child's prescription, which includ the information listed below. I have also provided my child's school with an extra supply of his/her medication wi a prescription label for use in the event that he/she forgets to bring his/her allergy medication to school on particular day. I understand that this permission for self-administration of medication is only effective for tl _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any clain I might have against the school district, its employees and agents, arising out of my child's self-administration said medication. In addition, I agree to indemnify and hold harmless the school district, its employees and agent either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred resulting from the self-administration of said medication, except a claim based on willful or wanton conduct.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE PHYSICIAN

LIFE THREATENING ALLERGY TO: _____ MEDICATION: _____

DOSAGE_____ SIDE EFFECTS_____

DATE OF PRESCRIPTION: _____ DISCONTINUATION DATE: _____

_____ has a life threatening allergy that medically necessitates the immedia administration of Epinephrine followed by emergency medical attention. It is medically necessary for him/her always carry an auto injector device. The student has been instructed in the self-administration of the abo mentioned medication and is capable of doing this independently. The student understands the necessity to notify staff member immediately following the self-administration of the Epinephrine auto injector so they may call 91 and monitor my condition.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____	_____	
Phone Number of Physician	Signature of Physician	Date
_____	_____	
Address of Physician	Print Name of Physician	Date

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AUTHORIZACION PARA EL ESTUDIANTE
PARA LA AUTO-ADMINISTRACION DEL MEDICAMENTO EPINEFRINA

NOMBRE DEL ESTUDIANTE: _____ CURSO: _____ FECHA DE NACIMIENTO: _____

DIRECCION: _____ TELEFONO: _____

Yo _____ padre/madre/tutor de _____ declaro que mi hijo/a ha sido diagnosticado/a con una alergia el/la cual puede correr riesgo de vida y se le ha recetado el medicamento epinefrina por un medico calificado como Profesional de salud. Autorizo a mi hijo/a para que lleve el siguiente medicamento y para que se auto-administre su medicamento recetado por su medico. Mi hijo/a entiende la necesidad de este medicamento y la necesidad de informar al personal de la escuela cualquier efecto secundario. Notificare a la escuela de los cambios en el medicamento o cambios en la condición de mi hijo/a. He proporcionado a la escuela con una copia de la receta de mi hijo/a, lo cual incluye la información listada abajo. También he proporcionado a la escuela de mi hijo/a con un suministro extra del medicamento con la etiqueta del medicamento para usarlo en caso de que se olvide de traer su medicamento para la alergia a la escuela en un día particular. Entiendo que este permiso para administrarse el medicamento es solo efectivo para el año escolar _____ y tendrá que renovarse cada ano escolar subsecuentemente.

También se y estoy de acuerdo en que cuando el medicamento recetado se administre, renuncio cualquier reclamo que pueda tener en contra del distrito escolar, sus empleados y agentes, cuando surja de la auto-administración de mi hijo/a con dicho medicamento. Además, estoy de acuerdo de indemnizar y mantener indemne al distrito escolar, sus empleados y agentes, ya sea conjunto o por separado, de y en contra cualquier y todo reclamo, daños, causas de acción o daños sufridos o como resultado de la auto-administración del dicho medicamento, a excepción de una reclamación basada en la conducta voluntaria o intencional.

Firma del padre/madre/tutor: _____ Fecha: _____

PARA SER COMPLETADO POR EL MEDICO

RIESGO DE VIDA A LA ALERGIA DE: _____ MEDICAMENTO: _____

DOSIS_____ EFECTOS SECUNDARIOS_____

FECHA D ELA RECETA: _____ FECHA DE DISCONTINUACION: _____

_____ tiene una alergia en el que puede correr riesgo de vida que médicamente necesita la administración inmediata de Epinefrina y consecuentemente atención medica de emergencia. Es necesario médicamente para el/ella que siempre lleve un aparato de auto-inyección. El estudiante ha sido enseñado en auto-administrase el medicamento mencionado arriba y es capaz de hacerlo independientemente. El estudiante entiende la necesidad de notificar a un miembro del profesorado inmediatamente siguiéndole con la auto-administración de la Epinefrina con la auto-inyección para que puedan llamar al 911 y puedan controlar su condición.

Me pueden contactar al numero de teléfono siguiente en el acontecimiento de una reacción al medicamento o emergencia.

_____ _____
Teléfono del medico Firma del medico Fecha

_____ _____
Dirección del medico Nombre por escrito del medico Fecha

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STUDENT AGREEMENT TO COMPLY WITH THE RULES FOR SELF-ADMINISTRATION OF EPINEPHRINE MEDICATION AT SCHOOL AND AT SCHOOL RELATED ACTIVITIES

I, _____, state that I have been diagnosed with a life threatening allergy and have been prescribed epinephrine medication by a qualified health care professional. I hereby agree to comply with the following rules for self-administration of epinephrine medication:

1. I acknowledge that I have received education from my health care provider to self-administer medication at school.

2. I will take care to keep my epinephrine auto-injector in my possession and under my control at all times.

3. I will never share my medication with another individual.

4. After self-administering my epinephrine medication, I will immediately contact a staff member so they may call 911 and monitor my condition.

I understand that if I am discovered to be abusing my epinephrine medication or using it improperly, my parent/guardian will be notified and I may lose the ability to self-administer my medication at school.

Student Signature: _____ Date _____

Parent Signature: _____ Date _____