TIMOTHY CHRISTIAN SCHOOLS

Student Prescription Medication Administration Authorization

Student Name_____ Grade_____ Teacher_____

*This form must be completed fully and turned into the Nurses' Office **BEFORE** any prescription medication will be administered. A new Student Medication Administration Authorization (SMAA) must be completed and signed by the parent/guardian and physician 1) at the beginning of each school year, 2) for each medication, and 3) any time there is a change in the prescription of medication. In addition, a form must be completed if a student will require medication while attending an overnight field trip.*

All prescription medications must be in the original container and have a pharmacy label that includes the student's full name, doctor's name and telephone number, name of medication, strength of medication, and specific directions regarding the dosage and administration of medication. It is the parent's responsibility to provide refills if needed. The student's parent must pick up all medication at the end of the school year or upon discontinuation of use, whichever occurs first.

MUST BE COMPLETED AND SIGNED BY PHYSICIAN

Name of Medication:_____

Diagnosis required medication:_____

Dosage:_____ Frequency:_____

Time medication is to be administered or under what circumstances:_____

Discontinuation/Re-evaluation date (circle one and identify date):_____

Expected side effects (if any):_____

Additional Instructions (if any):_____

Other medications student is taking (if any):_____

Physician's signature confirms necessity of medication administration during the school day or during an overnight field trip.

Physician's Name (printed)_____

Telephone_____ Fax_____

Address_____

Physician's Signature_____ Date _____

(Use for Physician's Address Stamp)

TO BE COMPLETED BY PARENT/GUARDIAN, AS NEEDED

EPINEPHRINE AUTO-INJECTOR (EPI-PEN)

Please turn into the nurse's office a completed Illinois Allergy Emergency Action Plan

_____ (initial) I give permission for my child to carry and self-administer his/her epinephrine auto-injector medication during the school day, at school activities, and at overnight field trips (if applicable).

_____ (initial) Please store my child's epinephrine auto-injector medication in the nurse's office where my child can access it during the school day and during school events. I acknowledge that for overnight field trips (if applicable), I will be notified where and how my child's epinephrine auto-injector medication will be stored.

ASTHMA INHALER

Please turn into the nurse's office a completed Illinois Asthma Action Plan

_____ (initial) I give permission for my child to carry and self-administer his/her asthma medication during the school day, at school activities, and at overnight field trips (if applicable). ***Please attach prescription label to the back of this form if child will self-administer.***

_____ (initial) Please store my child's asthma medication in the nurse's office where my child can access it during the school day and during school events. I acknowledge that for overnight field trips (if applicable), I will be notified where and how my child's asthma medication will be stored.

PARENT/GUARDIAN SIGNATURE, AS NEEDED

TO BE SIGNED ONLY BY PARENTS/GUARDIANS OF STUDENTS <u>WHO NEED TO CARRY AND USE ASTHMA MEDICATION OR AN EPINEPHRINE AUTO-INJECTOR</u>:

"Self-administration" refers to a student's discretionary use of his/her prescribed asthma medication or epinephrine auto-injector (self-administration for these purposes does not include the self-administration of any other medications). Accordingly, I acknowledge that my child is responsible for having asthma medication or an epinephrine auto-injector available as needed, and that my child has demonstrated competency in the proper way to use the medication.

I authorize Timothy Christian School and its employees and agents to allow my child to self-carry and self-administer his/her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activities, (3) while under the supervision of school personnel, or (4) before or after school activities. I agree to indemnify, release, and hold harmless Timothy Christian School and its employees and agents against any claims, except a claim based upon willful and wanton conduct, including claims for professional discipline, as a result of any injury or other claim arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector.

Parent/Guardian Name (PRINTED)_____

Parent/Guardian Signature_____ Date_____

PARENT/GUARDIAN SIGNATURE REQUIRED

TO BE SIGNED BY ALL PARENTS*:*

By signing below, I agree that I am primarily responsible for administering medication to my child. I hereby acknowledge that I have reviewed and understand Timothy Christian School's medication policies. I hereby authorize Timothy Christian School and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described on this form. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I agree to indemnify, release, and hold harmless Timothy Christian School and its employees and agents against any claims or obligations arising out of Timothy Christian School's medication policy and procedures and the administration of medication to my child or the child's self-administration of medication. I agree and specifically authorize school administration to provide health information related to the administration of medication described on this form to designated Timothy Christian School employees or parent chaperones, if deemed necessary by Timothy Christian School, in order for my student to participate in school activities during or outside the school day. I hereby give consent for the exchange of information between Timothy Christian School and the above-named physician, and the physician's staff, as needed regarding the administration of the medication described on this form.

Parent Name (printed) _____

Parent Signature_____ Date_____

Parent Daytime Phone Number(s) _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone Number(s) _____

OFFICE USE ONLY

Order reviewed by school RN:

Signature_____ Date_____

Notes_____

Allergy Emergency Action Plan on file _____

Epinephrine auto-injector Self-Carry/declined providing extra _____

Asthma Action Plan on file _____

Asthma Self-Carry/declined providing extra inhaler _____