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.

Authorization of Self Carry/Self Administation Of Epinephrine/Antihistamine, Diabetic Medication, Asthma Medication : _____ Yes _____ No
I have determined that it is medically necessary for the child to possess his/her medication and the equipment and supplies necessary to monitor and treat his/her condition pursuant to his/her Medical Management Plan. The student has been instructed in the self administration of the medication(s) listed above 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, lack of remedying of symptoms, or worsening condition. In the event of self administration of benadryl and/or epinephrine auto-injector, 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 medication.

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

Parent Authorization for Self-Carry/Self Administration of Epinephrine/Antihistamine, Diabetic Medication, Asthma Medication

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

Parent/Guardian Signature: _____ Date: _____

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

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: _____

3/2020