

Dear Parent/Guardian:

Evanston/Skokie School District 65 believes that medication should be administered in the home when at all possible. However, if it is necessary for your child to take medication at school, you must read and complete the following form:

In accordance with State guidelines and regulations , all medications administered in school, including non-prescription drugs, must be prescribed by a licensed health care provider. This medication authorization form, with specific directions, must be obtained from the students' licensed health care provider and provided to school personnel, along with a written request from the parents/guardian requesting that medication be given and/or self-administered during school hours using this form and completing the information below.

Please note that medicine can only be given by school personnel if authorized by a physician or qualified provider. Students who need to carry and use their epinephrine, insulin or asthma medication must have signed orders under a qualifying plan from both, the physician and/or qualified provider, and the parent/guardian. The written order must include the licensed prescribers name, signature, stamp and date as required below.

PARENTAL MEDICATION REQUEST

By signing below, I agree that I am primarily responsible for administering medication to my student. However, in the event that it is necessary for medication to be administered during the school day, I hereby request and grant permission for Evanston/Skokie School District 65 and its employees and agents, on my behalf, to administer or to attempt to administer to my student, or to allow my student to self-administer pursuant to State law, while under the supervision of the employees and agents of Evanston/Skokie School District 65, lawfully prescribed medication in the manner described on the following page. I acknowledge that it may be necessary for the administration of medication to my student to be performed by an individual other than the school nurse and specifically consent to such practices. I authorize Evanston/Skokie School District 65 and its employees and agents to communicate with my student's prescribing physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority regarding my student's medication administration and/or medicating condition. I further agree to indemnify and hold harmless the School District, its Board of Education, Board members, officers, employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of medication to my student.

I will notify the school of any change in medication or dosage and will provide an updated Medication Request Form with updated orders from the physician when a change is necessary.

STUDENT NAME

MEDICATION

PARENT'S/GUARDIAN'S SIGNATURE

DATE

Authorization for the Administration of Medication in School

This form is to be used for medication other than medical cannabis. A new form must be completed every school year for each medication.

(To be completed and signed by prescribing physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority)

Student Name: _____ DOB: _____ ID#: _____

Medication Name: _____

Purpose of Medication: _____

Dosage: _____ Frequency: _____

Time Medication is to be Administered and under what Circumstances:

Diagnosis requiring Medication: _____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Intended Effect: _____

Possible Side Effects: _____

Time Interval for Re-Evaluation: _____

Other medications student is receiving: _____

Special considerations: _____

All medication administered in school must be in the original packaging with the prescription label attached. Over-the-counter medication must be in a sealed bottle with the manufacturer's original label with the ingredients listed and the student's name affixed to the container and on the packaging.

Physician or Qualified Provider signature

Date

Physician/Qualified Provider Name: _____

Address: _____

Phone #: _____ Fax: _____

Prescribers Office Stamp

Self-Carry / Self-Administration Authorization

For parents/guardians of students who need to carry and use their asthma inhaler, insulin, or an epinephrine auto-injector:

As indicated by my initials below, I authorize the Evanston/Skokie School District 65 and its employees and agents, to allow my child or ward to self-carry and self-administer his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school programs on school-operated property. Illinois law requires the School District to inform parents(s)/guardians(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30).

As indicated by my initials below, I authorize Evanston/Skokie School District 65 and its employees and agents, to allow my student to self-carry and self-administer his or her prescribed epinephrine, insulin (pursuant to a diabetes care plan), or asthma medication. I hereby verify that my health care provider has instructed my student in the proper self-administration of his or her medication. I agree to indemnify and hold harmless the School District, its Board of Education and Board members, and its officers, employees and agents from any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of allergy, asthma or diabetes medication to my student. I understand that the School District and its employees and agents shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of an epinephrine injector, insulin or asthma medication.

Parent/Guardian Initials: _____

For parents/guardians of students who need to self-administer medication required under a qualifying plan:

As indicated by my initials below, I grant permission for my child to self-administer his or her medication required under an asthma action plan, an Individualized Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization Form, a plan pursuant to Section 504 of the Federal Rehabilitation Act of 1973, or a plan pursuant to the federal Individuals with Disabilities Education Act. I understand that the School District and its employees and agents shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration. 105 ILCS 5/10-22.21b, amended by P.A. 101-205, eff. 1-1-20.

Parent/Guardian Initials: _____

STUDENT NAME

MEDICATION

PARENT'S/GUARDIAN'S SIGNATURE

DATE

Authorization for the Self-Administration of Epinephrine, Insulin, Asthma Medication or Medication Required under a Qualifying Plan

This form is to be signed by prescribing physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority where it is necessary for student to self-administer his/her medication during the school day.

I certify that the identified student has been instructed in the use and self-administration of his/her medication. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently under the direct supervision of school personnel.

Student name

Medication

Physician/Qualified Provider Signature

Date

Prescribers Office Stamp