

Permission for Administration

of Prescription Medication by School Personnel

This form must be completed by a Parent/Guardian and uploaded to Magnus Health. Complete this form only if you want to keep prescription medication at school for your child. You must provide DCP with any medication your child takes. This form **MUST** be completed entirely and signed by the child's licensed medical provider and their parent/guardian. This form is effective only for the school year for which it is granted. All medications that need to be stored in the nurse's office must be brought in by the parent/guardian in the original prescription-labeled container.

Part 1 This Section to be Completed by Parent/Guardian

Name of Student: _____ Date of Birth: _____

Part 2 This Section to be Completed by a Physician

Name of Medication(s)	Health Condition for which Medication is Prescribed:
Time(s) to be Taken	Dosage
Route of Administration	Precautions / Possible Reactions
Name of Physician (Please Print)	Physician's Telephone Number
Physician's Signature	Date

For Diabetes Monitoring Supplies, Asthma Medication or Epinephrine Auto-Injector Only*:

I authorize DePaul College Prep and its employees to allow this student to carry and self-administer their medications for allergies, asthma, and/or diabetes.

- ☐ **YES**, the student may self-carry and self-administer
☐ **NO**, the student may not self-carry or self-administer

APPROPRIATE ASTHMA ACTION PLAN, ALLERGY ACTION PLAN, or DIABETES ACTION PLAN has been uploaded to Magnus. ☐ Yes ☐ No

****Students cannot self-carry unless the appropriate action plan is uploaded.***

**Pursuant to Illinois law, upon parental consent, a student who is prescribed asthma medication or an epinephrine auto-injector may possess and use his/her asthma medication during school or at school-sponsored activities without the supervision of DCP personnel.*

Part 3: This Section to be Completed by Parent/Guardian

I give permission for my child to receive the above medication at school according to DCP policy and administrative regulations, and agree to release, indemnify and hold harmless DCP's board members, officers, agents & employees from lawsuits, claims, demands, actions or expenses that may arise against them for administering medication as set forth in accordance with the provisions above.

I understand that medication as prescribed above for a student will be stored in a locked cabinet in the nurse's office. I understand that the student takes responsibility for timely visits to the nurse's office for their medication; they will not be reminded. I understand that the nurse will supervise the self-administration by student of their prescribed medication.

I understand that I may terminate consent for such administration of medication at any time, in writing. I will notify the school immediately if my child's health status changes.

I understand that medication/health information may be shared with Depaul College Prep staff on a need to know basis.

I have read and understand the guidelines listed above.

☐ Yes

☐ No

I authorize school personnel to administer this medication to my child.

☐ Yes

☐ No

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: _____

Relationship to Student: _____

Emergency Contact Phone Number: _____

Date: _____