Antioch Community Consolidated School District 34

Permission to Self-Carry/Administer Prescribed Medication

Student's Name_____ Birth Date_____

School_____ Date_____

Written order and permit for self administration of prescribed medication **(asthma inhaler or Epi-Pen)** while in school, at school sponsored activities, before or after normal school activities, or whenever the student is engaged in activities that are under supervision of school personnel.

(This section must be completed and signed by the student's physician)

Name of Medication _____

Date of Prescription_____

Dosage_____ _____

Route of Administration_____ _____

Frequency and Time of Administration_____

Discontinuation Date_____

Diagnosis Requiring Medication_____

Intended Effect of the Medication_____

Possible Side Effects_____

Date for Re-evaluation_____

Other Medications Student is Receiving_____

Printed Name of Physician_____

Address_____ Phone #_____

Physician's Signature_____ Date _____

(This section must be completed by the student's parent or guardian)

Pursuant to the authority granted under Section 105ILCS 5/22-30 of the Illinois School Code. I hereby authorize my son/daughter, _____, to have in his/her possession the above referenced medication to be self-administered as deemed necessary. My child has been instructed how to self-administer the prescribed medication.

I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees and volunteers from any loss or liability, including reasonable attorneys' fees, suffered by any of the foregoing indemnities and arising out of a claim related directly or indirectly to my son/daughter's self-administration of the above referenced medication, brought by me, any other parent or guardian of my student, or by or on behalf of my student.

I will instruct my child to report the usage to the school nurse. I will also instruct my child not to share the medication with any other student or use the medication in any disruptive way. I understand that the student may be disciplined according to the district student discipline policies for any disruption to the education of other students.

Parent/Guardian's Signature_____ Date_____

Home Phone_____ Work/Cell Phone_____

Self-Carry/Administration Medication Procedure

Antioch School District 34 requires that a parent/guardian and the student's physician complete the Permission to Self-Administer Prescribed Medication Form. This form must be turned into the health office in order for your student to carry his/her medication. Without this documentation the student will not be allowed to carry medication at school.

1. The top part of the form must be completed and signed by the student's physician.
    - Name of Medication/Date/Dose/Route/Time of administration
    - Diagnosis Requiring Medication/Effect/Possible Side Effects
    - Licensed Prescriber's Name/Signature/Phone Number

2. The bottom part of the form must be completed and signed by the parent/Guardian.
    - Parent/Guardian signature/phone numbers in case of emergency

3. Medication should be labeled with Student's Name.

4. Any changes in the medication (name, type, etc.) or dosage requires an updated form to be completed by the prescribing physician.

5. The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year.

6. A student may possess and use his/her medication while in school, at school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities.

We recommend that you provide an additional dose of the medication to be kept in the Health office in the event that your student forgets or loses his/her medication.