Glenview School District
1401 Greenwood Rd
Glenview, Illinois 60026

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Parent or Guardian:
Both pages of this form must be completed prior to the administration of any medication in accordance with district policy and guidance from the Illinois State Board of Education.
All medications provided to the school must be:

- In their **original prescription container,** labeled with the name of the student, prescribing physician, name of medication, dosage, route, time to be given and name of pharmacy

OR

- In the **original manufacturer's package** if non-prescription medication.
- The parent/guardian or other responsible **adult should bring any medication to the school health office**.

Student Name:_____Date of Birth: _____

To Be Completed by Physician:

Only medication which is prescribed by a physician and which are absolutely necessary for the critical health and well being of the student shall be given. Please indicate whether this medication must be taken during the school day. **Yes ☐ No ☐**

Medication: _____ Dosage: _____

Route:_____ Frequency:_____ Scheduled ☐ PRN ☐

Additional Specific Instructions: _____

Diagnosis/ Indication / Intended Effect:_____

Possible Side Effects: _____

Other Medication(s) Student is taking: _____

Duration of Order: Current School Year or other: (specify duration) _____

Emergency Medications: Epinephrine or Inhaler: (MD/PA/NP must initial below):

_____Student may self-carry/ self-administer their emergency medication.
I have instructed the student on the administration of this medication and find that they are able to administer this medication independently. (It is recommended that "back-up" medication be stored in the school health office).

Licensed Prescriber:

Prescriber name: _____ Phone Number: _____
(printed)

Signature: _____ Date of Order: _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Parent/ Guardian Authorization for School Medication

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize Glenview School District 34 and its employees and agents, on my behalf, to administer or 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 above. This includes administration of undesignated epinephrine injectors, albuterol or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction, asthma attack or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff 1-1-19. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a certificated and registered school nurse, and I specifically consent to such practices, and.

I agree to indemnify and hold harmless District 34, members and its employees, and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

In the event an epinephrine auto-injector is administered to my child, I acknowledge and understand that the school district personnel will call 9-1-1 to alert emergency services.

I agree to notify the school of any changes in medication for my child's condition.

I understand that I will need to pick up any unused doses of the medication at the end of the school year. Unused medications will not be sent home with my child and will be destroyed if not picked up by the last day of school.

Parent/ Guardian Signature: _____ Date: _____

Guardian Phone Number(s): _____

Parent/ Guardian Agreement Authorizing Self Carry/ Self Administration of Asthma Medication or Epinephrine Auto Injector

Before your child will be allowed to self-carry/ self-administer medication, we must ask you to sign below:

I agree with the provider statement above, and therefore authorize Glenview District 34 and its employees and agents, to allow my child to self-carry and/or self-administer the above named medication (1) at school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) during before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois Law requires the school district to inform parent(s)/ guardian(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, amended by P.A.s 99-480 and both 100-726 and 100-799 eff. 1-1-19)

The permission for self-administration of medication is effective for the school year in which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. We recommend that you provide an additional dose of the medication to be kept at the school in the event that your child forgets or loses his/her medication.

Your signature below indicates receipt of the above information as well as authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian Signature: _____ Date_____

Witness:_____ Date_____

The student must complete the following section (for self-carry):

I agree to:

1. Demonstrate correct use of the inhaler or epinephrine auto-injector using a trainer to the school health office staff
2. Never share my medication with another person
3. Notify a responsible adult if there is no improvement in my breathing after using my inhaler

OR

4. Immediately notify a responsible adult if I use my epinephrine auto-injector.

Student Signature_____ Date _____