Community Consolidated School District 15
580 North First Bank Drive
Palatine, Illinois 60067

MEDICATION and HEALTH CARE TREATMENT AUTHORIZATION

STUDENT NAME: _____ **Birthdate** _____

School _____ **Teacher** _____ **Grade** _____

District 15 believes that parents/guardians have primary responsibility for the administration of medication to their children. Therefore, the Board of Education discourages the administration of medication during regular school hours and during school-related activities, unless necessary for the critical health and well-being of the student.
Medication brought to school for administration must be in its original container from the pharmacy or healthcare provider and clearly labeled with:

1. Student's name 2. Drug name and dosage 3. Schedule for medication administration

Note: Medication must be brought into school by a parent/guardian and medication remaining at the end of the year or when medication is discontinued must be picked up by a parent/guardian.

Parent/Guardian and physicians must complete and sign this form before medication may be administered.

Students who need to keep their asthma medication/inhaler and/or epinephrine auto-injector with them for self-administration must also have a completed **EMERGENCY MEDICATION AUTHORIZATION** form.

PARENTAL AUTHORIZATION

I authorize Community Consolidated School District 15/C.A.R.E. and its employees and agents to administer medication according to the Medication Administration Policy and Procedures of CCSD15 to my child.
PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Comments: _____

PHYSICIAN or LICENSED PROVIDER ORDER

STUDENT NAME: _____ **Date:** _____

Medication/Health Treatment _____

Specific Time/Instructions _____ **Dosage** _____ **Route** _____

Reason for Medication/Health Treatment and Intended Effect _____

Possible side effects _____

Possible negative drug interactions _____

Length of Time for Administration _____ **Start Date** _____ **End Date** _____

Comments/Additional Instruction _____

Approved for Possession and Self-administration of

Inhaler ☐ **Yes** ☐ **No** **Epinephrine Auto-injector** ☐ **Yes** ☐ **No**

☐ Emergency Action Plan and/or Medical Management Plan attached

Signature: _____

PRINT NAME: _____

☐ **Inhaler rescue medication labeled by pharmacist**

Insert doctor's stamp here:

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HOLD HARMLESS AND INDEMNITY COMMITMENT EMERGENCY MEDICATION AUTHORIZATION ASTHMA MEDICATION/INHALER AND EPINEPHRINE AUTO-INJECTOR

This form shall be effective for the 20__–20__ school year only, and must be renewed each subsequent school year.

Student's Name_____ Birthdate_____ School_____

The student's parent or guardian must complete this section:

Pursuant to the authority granted under Section 105 ILCS 5/22-30 of the Illinois School Code, I hereby authorize my son/daughter, _____, to self administer the above referenced medication at school, school-sponsored activities, while under the supervision of school personnel, and before/after normal school activities such as before/after school care on school operated property. (*We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her 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 claim, liability, loss or expense including reasonable attorneys' fees, suffered by any of the foregoing indemnitees and arising out of a claim related directly or indirectly to my son/daughter's self-administration of the above referenced medication or brought by me, any other parent or guardian of my student or another student, or by or on behalf of my student or another student. We understand that the School District and foregoing individuals are to incur no liability as a result of any injury arising from the self-administration of medication, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.

Parent Signature _____ Date _____

The student must complete this section:

I agree to:

- Demonstrate correct use of the inhaler or epinephrine auto-injector using a trainer/demonstrator to the registered nurse at school.
- Never share the inhaler or epinephrine auto-injector with another person.
- Notify a teacher or other responsible adult if there is not marked improvement in my breathing within several minutes after two puffs of the inhaler.
- Immediately notify a teacher or another responsible adult if I use my epinephrine auto-injector.

Student Signature _____ Date _____