GLENVIEW 34
SCHOOL DISTRICT

Complete this form ONLY if you want to keep medication at school for your child. You must provide any medication your child takes. This form MUST be completed entirely and signed by the child's doctor and parent/guardian. The consent for self-administration of medication is effective only for the school year for which it is granted.

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

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

Name of Student:_____ Date of Birth:_____

Address:_____

Emergency Phone Numbers: H: _____ W: _____ Cell: _____

School: _____ Grade: _____

Part II: This Section to be Completed by Physician *(This statement may be signed by a physician's assistant or advance practice registered nurse having such authority delegated by a supervising/collaborating physician.)*

1. Name/type of medication:_____
2. Is the prescribed medication for an asthmatic condition? _____
3. Is the prescribed medication for anaphylaxis?_____
4. Dosage/amount to be given: _____
5. Route of administration: _____
6. Frequency and time of administration:_____
7. Duration (week, month, till end of current school year):_____
8. Diagnosis, intended effect and anticipated reaction to medication (symptoms, side effects, etc.): _____

   _____
9. Other medication(s) student is receiving: _____
10. Other requirements or special circumstances: _____
11. Must this medication be administered during the school day in order to allow the student to attend school? [ ]Yes [ ]No
12. Is supervised student self-administration authorized? _____
13. **For Asthma Medication or Epinephrine Auto-Injector Only*:**
    Is unsupervised self-administration authorized? [ ] Yes [ ] No
    **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 District personnel.*
    Student has demonstrated and understands appropriate use of asthma medication. _____yes?
    Student has demonstrated and understands appropriate use of epinephrine auto-injector ____yes?

Physician's Signature: _____ Date:_____

Address: _____ Telephone #:_____

Part III – Parent's Request/Approval

I hereby request and grant permission for Glenview School District #34 school personnel to [*check one*] [ ] administer or [ ] permit the self-administration of medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I further waive any claims against the School District, members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication. With respect to student self-administration of asthma medication, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

For Asthma Medication or Epinephrine Auto-Injector Only:

I consent to my child's possession and unsupervised self-administration of asthma/epinephrine medication: [ ] yes [ ] no

Parent/Guardian Signature:_____ Phone # _____Date _____