



Antioch CCSD 34
Permission to Self-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-administer 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 \_\_\_\_\_
Address \_\_\_\_\_
Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_