



**East Alton School District #13
Medication Administration/Self Administration Consent Form**

Student: _____ DOB: _____ Grade: _____ Teacher: _____
 Address: _____
 Home Phone: _____ Emergency Phone: _____

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize East Alton School District #13 and its employees and agents, in my behalf, to administer or to 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 East Alton School District #13), lawfully prescribed medication in the manner described below. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and I agree to indemnify and hold harmless East Alton School District #13 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.

Parent printed name: _____ **Signature:** _____
Date: _____

ASTHMA INHALERS/EPI-PENS (For only parents/guardians of students who need to carry asthma medication and/or epinephrine auto-injector)

Parent(s)/Guardian(s) please attach prescription label here

I authorize East Alton School District #13 and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires East Alton School District #13 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-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30)

Parent/Guardian initials: _____

PHYSICIAN'S STATEMENT *(To be completed by the student's physician, physician assistant, or advance practice RN)*

Is it necessary for this medication to be administered during the school day? Yes _____ No _____

Name of Medication: _____ Diagnosis _____

Intended Effect _____ Side Effects: _____

Dosage: _____ Route of Administration _____

Frequency and time of administration: _____

Duration (week, month, end of school year): _____

Prescription date: _____ Order date: _____ Discontinuation date: _____

Other medication student is receiving: _____

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ASTHMA:

- ★ Is the prescribed medication for an asthmatic condition? Yes No
- ★ Student has been taught and demonstrates knowledge of asthma signs and symptoms and demonstrates correct self-administration of asthma medication, whereby, student may CARRY and SELF-ADMINISTER medication unsupervised? Yes No
- ❖ **FOR ASTHMA: THE ATTACHED ACTION PLAN MUST BE COMPLETED**

EPI-PEN:

- ★ Is the prescribed medication an Epi-pen for an allergic reaction? Yes No
- ★ Student has been taught and demonstrates knowledge of allergic reaction and demonstrates correct self-administration of anaphylactic medication, whereby student is allowed to CARRY AND SELF-ADMINISTER anaphylactic medication unsupervised? Yes No
- ❖ **FOR EPI-PEN: THE ATTACHED EMERGENCY ACTION PLAN MUST BE COMPLETED**

Physician printed name: _____

Physician signature: _____ **Date:** _____

Office Address: _____

Office Phone # _____