COMMUNITY UNIT SCHOOL DISTRICT 200

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME______________________________ DATE OF BIRTH__________________

PARENT/GUARDIAN______________________________ HOME PHONE __________________

ADDRESS______________________________ GRADE/TEACHER__________________

TO BE COMPLETED BY THE PHYSICIAN: PHYSICIAN MUST AUTHORIZE CHANGES IN DOSAGE IN WRITING.

Name of Medication ____________________Administration Route__________Dosage______

Frequency__________Time to be Given in School ______________________________

Student's Diagnosis______________________________

Possible Side Effect(s)______________________________

Intended Effects of this Medication ______________________________

Time Interval for Re-evaluation of Prescription______________________________

Other Medication(s) Student is Receiving______________________________

Is it absolutely necessary that this medication be administered in school? Yes________ No________

Is this student authorized to self-carry and self-administer asthma medication? (See reverse side for guidelines)

Yes ________ No ________

______________________ ______________________ ________

PHYSICIAN'S NAME (PRINT) PHYSICIAN'S SIGNATURE DATE

______________________ ______________________ ________

ADDRESS PHONE - OFFICE PHONE -EMERGENCY

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

TO BE COMPLETED BY PARENT OR GUARDIAN:

I hereby confirm that I have reviewed and understand District 200's policy regarding the administration of medication in school. I hereby authorize District 200 and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child lawfully prescribed medication in the manner described on the Physician's Order for Administration of Medication in School form above.

I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Finally, I understand and agree that it is my responsibility according to District 200 policy to deliver the legally prescribed medication to and from the school myself or via another adult designee,
______________________________. (Name of Adult Designee)

______________________________ ______________________

Parent/Guardian Signature Date

(TO BE COMPLETED ONLY IF SELF ADMINISTRATION BY STUDENT IS BEING CONSIDERED): I authorize my child to self-carry and self-administer his/her asthma medication. I have read, understand, and agree to the School District's Guidelines for Self-Administration of Medication in School which are printed on the reverse side of the form. The location he/she will keep medication at school is ______________________

______________________________ ______________________

Parent/Guardian Signature Date Form#5141 4B Revised 03/02

ADMINISTRATION OF MEDICATION IN SCHOOL

DISTRICT 200 POLICY

Teachers and other non-administrative school employees, except nurses licensed by the State of Illinois, shall not be required to administer medication to students. Parent(s)/guardian(s) are responsible for administering medication to their children. Administering medication during school hours or during school-related activities is discouraged unless it is necessary for educational benefit and/or critical health and well being of the student.

Nothing in this policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

PARENT RESPONSIBILITIES

1. All prescription and non-prescription medications given at school require a doctor's order and parent permission. Parent/guardian must provide a completed "Physician's Order for Administration of Medication in School" form.
2. If there is a change in medication dosage during the year, the school must receive an updated physician's order in writing before the new dosage can be given.
3. Medication must be provided in its original container labeled by the pharmacist with the student's name, medication, and dosage as it is to be given at the school.
4. <u>Medications must be brought to school by a parent or a designated adult and are never to be sent to school with the student</u>. Exceptions are asthma medications self-carried and self-administered.

GUIDELINES FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

1. The student who participates in self-administration of asthma medication must demonstrate consistent responsibility regarding:
   A. Understanding when it would be medically appropriate to take medication.
   B. Knowing how to administer the medication and how frequently it can be taken.
   C. Being familiar with expected effects and possible side effects of the medication.
   D. Understanding that medication is not to be shared with anyone.
   E. Seeking additional help from the teacher or health office if symptoms persist or if student is experiencing side effects.
2. The student's name must be marked on the inhaler in case it is misplaced.
3. The School will not keep a record of medication administration for the student.
4. The privilege will be revoked for safety reasons if the student does not demonstrate appropriate responsibility.