



HAMILTON COUNTY COMMUNITY UNIT DISTRICT NO. 10

PO Box 369
804 Golf Course Road
McLeansboro, Illinois 62859
(618) 643-2328

MEDICATION FORM

Student _____ Grade _____ Teacher _____

By signing below I agree:

- 1. That I'm 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 the School District and its employee and agents, in my behalf and steady; to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described 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 school nurse, (delegated by the school principal) and specifically consent to such practices; and
2. To identify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of self-administration of medication by the pupil.
3. Medication must be brought to school by parent/guardian in a container properly labeled by the pharmacy or physician; non-prescription medication ordered by the physician should be brought with the original label and the students name affixed to the container. Only medications that are necessary to maintain the student in school or must be given during school hours shall be administered.

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication or epinephrine pen.

- 1. While in school
2. While at school-sponsored activity.
3. While under the supervision of school personnel
4. Before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District 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 (105 ILCS 5/22-30) or when the school nurse or trained staff member in good faith, believes the student is having an anaphylactic reaction and administers an inhaler or epinephrine as ordered.

Parent/Guardian printed name

Parent/Guardian signature Date

To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office or assigned staff member's location.

Student's Name: _____ Birth Date: _____ Address: _____

Home Phone: _____ Emergency Phone: _____ School: _____

To be completed by the student's physician:

Physician's Printed Name: _____ Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication: _____ Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

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

Diagnosis requiring medication: _____ Intended effect of this medication: _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? Yes _____ or No _____

Expected side effects, if any: _____ Time interval for re-evaluation: _____

Other medications student is receiving: _____

Physician's Signature

Date