Waterloo Community Unit School District #5

Self-Carry Medication Approval Form

Asthma: A student with asthma will be permitted to self-carry and self-administer asthma medication upon 1) written authorization of the parent, and 2) a prescription label with the name of the medication, the prescribed dosage, and the time or circumstances under which the medication is to be administered.

Allergies: A student with allergies will be permitted to self-carry and self-administer an epinephrine auto-injector (i.e. EpiPen) upon 1) written authorization of the parent, and 2) written authorization from the student's physician, and 3) a written statement from the student's physician containing the name and purpose of the EpiPen, the prescribed dosage, and the time or circumstances under which the EpiPen is to be administered.

It is the parent's responsibility to ensure that the licensed prescriber's order, written request and medication are brought to the school. At the end of the school year or the end of the treatment regime, the student's parent(s) or guardian will be responsible for removing from the school any unused medication. If the parent does not pick up the medication within two weeks of the last day of attendance, it will be disposed of.

Under Illinois law authorizing student self-carry and self-administration of asthma medication or EpiPens, the liability of the school district from any injury arising from the administration of medication, except for willful and wanton conduct, is limited. This limited liability, except for willful and wanton conduct, also includes physicians providing the prescription for self-carry and self-administration. The law further provides that the limited liability is in effect even without a parent's signed statement acknowledging the limitation of liability.

If you have any questions regarding this policy, please consult your building principal or nurse.

I request that _____ _____ _____
(Student Name) (Grade) (Date of birth)
be given allowed to self-carry and self-administer the following medication at school and at school-sponsored activities while under the supervision of school personnel, as prescribed by his/her physician. I also authorize, as needed, the sharing of information related to my child's health between the school nurse and the health care provider listed below. I understand that it may be necessary for the administration of medication to students to be performed by an individual other than a school nurse, and specifically consent to such practice. I acknowledge that the liability of the school district from any injury arising from the administration of this medication, except for willful and wanton conduct, is limited.

_____ _____
(Parent's Signature) (Phone Number)

To be completed by Physician

Name of drug:_____ Dosage and Route:_____

Frequency and Time to be Given:_____

Diagnosis:_____ Possible Side Effects:_____

_____

Intended Effect of Medication:_____

Other Medications child is Receiving:_____

Time Interval:_____until_____
(Date Treatment should begin) (Date Treatment should end)

_____ _____
(Physicians Signature and Date) (Physicians Phone and Emergency Number)

_____ _____
(Print name of Physician and date) (Address of Physician)