ATTENTION:

SELF ADMINISTRATION OF MEDICATION FORMS (ASTHMA, EPI-PENS, OTHER)

PHYSICIAN AUTHORIZATION
SELF-ADMINISTRATION OF MEDICATION - DISTRICT 233

_____ _____
Student Name Birth Date

_____ _____
Address Phone Number

_____

The above named pupil has _____
Name of medical condition (asthma, allergy, etc.)

I am requesting that this student take the following medication as prescribed during school hours (including while in a school sponsored activity and while under the supervision of school personnel):

Name of Medication

Purpose of Medication

Dosage and Times to be taken

Possible Side Effects

I certify that this student has been instructed in the use and self-administration of this medication and is aware of possible side effects.
He/she understands the need for the medication and the necessity to report to personnel any unusual side effects. He/she is capable of using this medication independently.

_____ _____
Prescriber's Signature Date Signed

_____ _____
Print Name of Prescriber Prescriber's Phone #

_____
Prescriber's Address

PARENTAL/GUARDIAN AUTHORIZATION
SELF-ADMINISTRATION OF MEDICATION – DISTRICT 233

_____ _____
Student Name Birth Date

The following guidelines shall apply to the self-administration of medication:

- ☐ Physician/Prescriber signed and dated authorization to administer the medication, with the name and purpose of the medication and the prescribed dosage and time for administration.
- ☐ Parent/Guardian signed and dated the parental/guardian authorization.
- ☐ The medication is in the original labeled container as dispensed or has the manufacturer label in place.
- ☐ If prescription, the label must contain the student name, name of the medication and directions for use.
- ☐ Annual renewal of authorization and immediate notification, in writing, of and changes are necessary.
- ☐ School District 233 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

PARENTAL AUTHORIZATION:

I acknowledge that I am the parent and/or legal guardian of the above named student and that I am responsible for administering medication to my child. However in the event that I am unable to do so, I hereby authorize School District 233 to allow my child to self-administer his or her lawfully prescribed medication during school, while at a school-sponsored activity, and while under the supervision of school personnel. I further acknowledge and agree that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of medication.

_____
Signature of Parent/Guardian Date Signed

_____
Home Phone Number Business Phone

_____
Signature of Parent/Guardian

_____
Home Phone Number Business Phone