Physician's Orders for Self-Administration of Medication at School

Date_____

Student_____ Birth Date _____

Diagnosis_____

Medication Name _____

Dose _____ Frequency_____

Desired Effect_____

Side Effects_____

I certify that _____ (*student)* has been instructed in the use and self-administration of _____ *(medication).*

He/She understand the need for the medication and the necessity to report to school personnel of any unusual side effects. He/she is capable of using this medication independently and should be allowed to carry this medication with their personal belongings.

Physician Name_____

Physician Signature_____ Date_____

Office phone number_____

Parent Consent

I hereby give consent for my child to self-administer the medication as prescribed and instructed by his/her physician. I understand and agree to comply with school policy on administration of medication during school hours, while at school sponsored activity or while under the supervision of school personnel. I fully understand the school district is to incur no liability as a result of any injury from the self-administration of the medication by the student. Illinois law requires the School District to inform parents/guardians the it, and it's employees, 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. (105ILCS 5/22-30) I also understand that medication must be kept in the original container with the child's name legible.

Parent Name _____ Phone Number_____

Parent Signature _____ Date_____