SOUTHERN WILL COUNTY COOPERATIVE for SPECIAL EDUCATION

ADMINISTRATIVE DISTRICT: TROY 30C

DR. TIFFANY FREY
Executive Director

ADMINISTRATIVE OFFICE:
815 N. LARKIN AVENUE - SUITE 107 | JOLIET, ILLINOIS 60435
phone:815.741-7777 fax:815.741-7779

GRACE DOYLE
Assistant Director

Authorization and Permission for Administration of Medication at School

Student's Name:_____DOB:_____Date:_____

School:_____

Any student who requires **prescription OR over-the-counter medication** during school hours MUST comply with the following regulations to comply with Illinois law and school board policy:

- Submit a healthcare provider's signed and dated AUTHORIZATION & PERMISSION FOR ADMINISTRATION OF MEDICATION AT SCHOOL (Page 1 of this form).
- Submit the parent/guardian signed and dated PARENT AUTHORIZATION TO ADMINISTER form to administer the medication while at school (Page 2 of this form).
- We require that medication must be brought to school by the parent/guardian and be in its original unopened manufacturer's container or in an original container properly labeled by the pharmacy. The prescription label must contain the student's name, medication name, dosage, and time the student needs to take the medication.
- All controlled substance medications **must be brought in by a parent and counted with the nurse each time the medication is dropped off** at the school.
- All medication must go through the nurse for approval and proper storage during the day. **We do NOT allow prescription or non-prescribed medications to be carried on a student while in school.**
- In all cases, the school retains the right and responsibility to reject a request for medication administration or refuse to administer any medication depending on individual circumstances and/or if proper procedures are not followed.
- You must provide the physician's name, address, and telephone number in case we need additional information.
- Annual renewal of authorization is required.
- Any changes to medications require immediate written notification.

Physician Authorization

Medication OR Health Care Treatment:_____Dosage:_____

TIme to be Administered:_____Intended Effect of Medication:_____

Possible Side Effects, if any:_____

Other medications student is taking:_____

May student self-administer medication under supervision of Health Service personnel or designate? ☐ YES ☐ NO

Administration instructions:_____

_____

Discontinue Date:_____

Prescriber's Name (Print):_____Phone:_____

Prescriber's Signature:_____Date:_____

Prescriber's Address:_____Fax:_____

See Parent Authorization on Back

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Assistant Director

Parent Authorization for Medication Administration/Self Administration at School

Student Name:_____DOB:_____

Medication:_____

I hereby authorize SOWIC personnel to ☐ **Administer** or ☐ **Permit the self administration** *(please mark answer)* of medication to or by my child during school hours according to the above instructions. I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize SOWIC and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under supervision of the employees and agents of SOWIC) lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I further waive any claims against SOWIC, its individual board members, employees, and agents arising out of the administration or self-administration of said medication, and agree to hold harmless and indemnify SOWIC, its individual board members, employees and agents, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication. I also acknowledge that SOWIC shall 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 or the storage of any medication by district personnel, regardless of whether the self-administration of an asthma inhaler or Epi-pen was authorized by the parent or healthcare provider.

FOR ASTHMA MEDICATION/EPINEPHRINE AUTO-INJECTORS ONLY: I authorize SOWIC and its employees and agents, to allow my child/ward to carry and self-administer his/her asthma inhaler and/or use his/her epinephrine auto-injector: (1) While in school (2) While at a 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/guardian that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of asthma medication or epinephrine auto-injector (1051lcs 5/22-30).

Parent/Guardian Name (Print):_____

Parent/Guardian Signature:_____Date:_____