REQUEST FOR ADMINISTRATION OF MEDICATION
Barrington 220
310 E. James St., Barrington, IL 60010

To Be Completed By Licensed Prescriber

_____ _____ _____
(Student's name) (Date of birth) (Grade/rm)

Should take _____ _____
(Name of Medication) (dosage)

At _____ by _____ for _____
(time of day) (route) (period of time)

Diagnosis of disease or injury _____

Desired benefits of medication _____

Medication side effects _____

Other medication student is receiving _____

<u>For Self Administration of asthma inhaler, epinephrine auto-injector, or insulin</u>:
Self-Administered (Pupil has the discretion as to the use of his/her medication)
( ) Yes
*I certify that _____ has been instructed in the use and self-administration of _____. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects.
*Under what circumstances:_____
( ) No

Doctor's name printed _____ Telephone_____

Address _____ Fax _____

Doctor's signature _____ Date _____

<u>To Be Completed By Parent/Guardian</u>
I agree that I am 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 employees and agents, in my behalf, 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 and specifically consent to such practices, and I agree to indemnify 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 the administration or the child's self administration of medication. I agree to the terms of the procedures for the administration of medication. I further completely release Community Unit School District 220 and its employees and agents of any liability or obligation of any nature in any way related to the I also understand that my signature on this form denotes permission for the school nurse and the prescribing physician to confer regarding the administration/monitoring of this medication.

_____ _____
Parent/Guardian signature Date

For students who need to carry asthma inhaler, epinephrine auto-injector or insulin: He/she is capable of using this medication independently while in school, while at school sponsored activities, such as in before-school or after-school care on school operated property. If you agree please initial: _____

<u>Medication Must Be Brought To School By The Parent/Guardian!</u>