Special Services for District 92

Kimberly West, Assistant Superintendent for Special Education

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PARENT AUTHORIZATION AND STUDENT AGREEMENT
TO CARRY AND SELF-ADMINISTER MEDICATION OR HEALTH PROCEDURE

Student's Name: _____ Birth Date: _____

Student's School: _____

Medication/Health Procedure: _____

Physician's Name*: _____

Date of Authorization*: _____

**Not applicable for asthma medication or epinephrine auto-injector*

Student Agreement

As the above named student, my signature below indicates that I understand and agree to the following:

1. I have demonstrated the proper administration of the above listed medication/health procedure to the School Nurse.
2. I agree to never share or ask another student to carry my medication or health procedure equipment in school and/or at school-related activities.
3. I agree that, if there are any problems or adverse side effects during or after self-administering the medication or performing the health procedure, I will ask a teacher or other school staff member for assistance and/or to notify my parent/guardian or the School Nurse.
4. I agree to inform a teacher or other school staff member immediately if I lose my medication or health procedure equipment in school and/or at school-related activities.

Student's Signature: _____ Date: _____

Parent/Guardian Authorization

By signing below, I give permission for my child or ward (named above) to receive the prescribed medication(s) and/or procedure(s) in school and/or at school-related activities. I agree that I am primarily responsible for administering medication to my child or ward. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize School District 92 and its employees and agents, on my behalf, to administer or to attempt to administer to my child or ward (or to allow my child or ward to self-administer pursuant to State law, while under the supervision of the employees and agents of School District 92), lawfully prescribed medication or procedure in the manner described above. **I understand that:** 1) the medication or procedure will be administered by the School District 92 School Nurse or Registered Professional Nurse, a District 92 Administrator, or other District 92 staff member who volunteers to do so; 2) no medication (prescription or over the counter drugs) will be given to my child or ward until all required signatures are received by School District 92; 3) the medication dosage will not be increased, decreased or discontinued without another proper prescription; and, 4) medication to be administered must be in its original container and appropriately labeled by the pharmacy. **I acknowledge that it may be necessary for the administration of medication to my child or ward to be performed by an individual other than a school nurse/registered professional nurse and specifically consent to such practices, and I agree to indemnify and hold harmless School District 92 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration to or the self-administration of medication by my child or ward.**

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____