CHAMPAIGN COMMUNITY SCHOOLS

Permit for Authorized Personnel to Administer Required Medication During School Hours

THIS PERMISSION MUST BE RENEWED EACH SCHOOL YEAR

The District believes that parents/guardians have primary responsibility for the administration of medication to their children. Therefore the District discourages the administration of medication during regular school hours and during school-related activities unless necessary for the critical health, well-being, and education of the student.

Student Name: ____ Student Age: ____________ Date of Birth: ________________

Grade: _______________ Homeroom/Classroom: ____

TO BE COMPLETED BY SCHOOL PERSONNEL

School: ________________________________ School Year: _______________ Date form received: __________________

I/we acknowledge receipt of this Physician's Statement and Parent Authorization: ___________________________________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: ____

Reason for medication: ____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Injection ☐ Other___________________________

Instructions: Specific Time/Instruction:__________________________________ Dosage _________________ Route ___________

Start: Date form received Other, as specified: _______________________

Stop: End of school year Other as specified: _______________________

For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:

____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other:

____

Physician's Signature _________________________________ **Physician's Name**____

*****For Self-Administration Only*** For Self-Administration Only*** For Self-Administration Only*****

*Pursuant to {******************} Champaign Community Schools District 4 permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.*

This student has been instructed on self-administration of this medication: **to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis) ONLY**

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ Illinois Food Allergy Emergency Action Plan ☐ As an attachment

Provider Signature: ____Date:______________________________

TO BE COMPLETED B PARENT/GUARDIAN

I give permission for ____________________ to receive the above stated medication (s) at school according to standard District policy and procedure. I understand that the District and my child's school have no liability for my child's self-medication. I agree to indemnify and hold harmless the District and/ or the school, along with its agents and employees, against any claim (except a claim based upon willful and wanton conduct).

I will bring the medication in a container appropriately labeled by the pharmacy to the school nurse, principal, or designee. I will notify the school in writing if the medication is discontinued. I understand that a new order is needed if the medication dosage is changed. I give permission for the School Nurse/Administration to contact the prescribing health professional about the administration of this medicine, and the condition it treats. I certify that I have administered at least one dose of the medication to my child without adverse effects.

Parent Signature: _____________________________________ Date: ____________________ Phone: ___________________________

Approved 6/2018