MEDICATION ADMINISTRATION / SELF-ADMINISTRATION CONSENT FORM

Name of Student__________________ Date of Birth__________________

Address__________________ Emergency Phone__________________

School__________________ Grade__________________

Part I – Physician's Statement *(This statement may be signed by a physician's assistant or advance practice registered nurse having such authority delegated by a supervising/collaborating physician.)*

1. Name/type of medication__________________
   Dosage/amount to be given__________________
2. Is the prescribed medication for an asthmatic condition?__________________
3. Route of administration__________________
4. Frequency and time of administration__________________
5. Duration (week, month, indefinite, etc.)__________________
6. Diagnosis__________________
7. Intended effect and anticipated reaction to medication (symptoms, side effects, etc.)__________________
8. Must this medication be administered during the school day in order to allow the student to attend school?__________________
9. **For Asthma Medication Only***: Is unsupervised self-administration authorized?__________________
   **Pursuant to Illinois law, upon parental consent, a student who is prescribed asthma medication may possess and use his/her asthma medication during school or at school-sponsored activities without the supervision of District personnel.*

__________________ __________________
Physician's Signature Date Signed

__________________ __________________
Address Telephone No.

Part II – Parent's Request/Approval

I hereby request and grant permission for Taylorville Community Unit School District #3 school personnel to *(check one)* ___ administer or ___ permit the self-administration of medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration or self-administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, 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. With respect to student self-administration of asthma medication, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

__________________ __________________ __________________
Parent/Guardian Signature Phone Date

For Asthma Medication Only: I consent to my child's possession and unsupervised self-administration of asthma medication: ____ Yes ____ No.

__________________ __________________ __________________
Parent/Guardian Signature Phone Date