

KANELAND COMMUNITY UNIT SCHOOL DISTRICT #302

A policy for administering medication to children while at school has been established following the guidelines from the Illinois Department of Human Services and the Illinois State Board of Education. The strict adherence of this policy is imperative for the safety and well-being of students and staff.

PLEASE FOLLOW THESE PROCEDURES:

1. All medication needed by the pupil during the day will be administered under the supervision of a school nurse.
2. The parent AND physician must complete the Medication Authorization form for both prescription and non-prescription medication. This includes pain medication, inhalers, throat lozenges, etc.
3. Medication forms need to be renewed annually.
4. All medication will be kept in the office. Students are not to have medication in their possession, unless written permission from the doctor.
5. All medication must be brought to school by a responsible adult.
6. Medication will be disposed of after the school year, if left at school.
7. If the medication dosage or time is changed, the parent and the doctor must submit in writing these changes to the nurse.
8. The primary responsibility for medication rests with the parent. We will only administer medication necessary to sustain a student during the school day.
9. Medication will be accepted in the original pharmacy container. Orders on the prescription container must exactly coincide with the order as written by the physician.
10. If a student requires emergency medication for food or insect allergy, please have your physician complete the Consent Form for Medication Authorization. The parent must supply the appropriate medication.
11. The parent must administer the initial dosage of medication at home in order to observe for side effects.
12. The school district and its employees shall incur no liability except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by a pupil.

Student Health Services

10/23/06

KANELAND COMMUNITY UNIT SCHOOL DISTRICT #302

MEDICATION AUTHORIZATION FORM

For this student to receive medication during the school hours or to carry asthma medication on school grounds or for school-sponsored activities, this form must be fully completed by the prescribing physician and an authorizing parent or legal guardian.

STUDENT NAME: _____ BIRTHDATE: _____

GRADE: _____ TEACHER: _____

MEDICATION/HEALTH CARE TREATMENT: _____

DATE OF THIS ORDER: _____ DISCONTINUATION DATE: _____

POSSIBLE SIDE EFFECTS: _____

DOSAGE AND TIME TO BE GIVEN: _____

INTENDED EFFECTS OF THIS MEDICATION: _____

____ I give permission for self-administration of an asthma inhaler. ____ I give permission for self-administration of an Epi-Pen.

Must this medication be administered during the day in order to allow the child to attend school or to address the student's condition? _____

Signature of Physician Physician's Phone Number Date

PARENT AUTHORIZATION

Asthma Medication: I agree with the information provided above by my child's physician regarding asthma medication. I also give permission for my child to possess and to self-administer on an "as needed" basis said asthma medication when my child is attending school, is under the supervision of school personnel, is at school-sponsored activities, or is on school property outside of regular school hours and regular school activities.

I herewith acknowledge 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 Kaneland School District and its employees and agents, on my behalf and stead, to administer or to attempt to my child lawfully prescribed medication in the manner described above. I further acknowledge and agree that I waive any claims I might have against Kaneland School District and its employees and agents arising out of the administration or attempted administration of medication to my child. I further agree to indemnify and hold harmless Kaneland School District and its employees and agents, either jointly or severally, against any claims arising out of the administration or attempted administration of medication to my child. If my child is authorized to self-administer asthma medication, I acknowledge and agree that Kaneland School District and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by my child. I further agree to indemnify and hold harmless Kaneland School District and its employees and agents, either jointly or severally, against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

I give the school nurse permission to be in contact with the prescribing physician with regards to the above medication order and the response my child has to the prescribed medication.

Parent's/Guardian Signature Phone Number Date

Kaneland Blackberry Creek 630-365-3905 (FAX) Kaneland Middle 630-365-6153 (Nurse's Office FAX)

Kaneland John Stewart 630-365-0651 (FAX) Kaneland High 630-365-5124 (Nurse's Office FAX)

Kaneland John Shields 630-466-5320 (FAX) Kaneland McDole 630-897-3229 (FAX)

