WASHINGTON
Community High School District 308

Permission Form for Prescribed Medication

Student Name: _____DOB:_____ Grade:_____

To be completed by the physician or authorized prescriber

Diagnosis/Reason for medication: _____

Name of medication: _____

Dosage/Amount/Route/Time: _____

Start Date: _____ Stop Date: _____ ( ) For episodic/emergency events only

Desired Benefits of Medication: _____

Possible Side Effects: _____

Medication must be in the original container

Date: _____ Physician Signature: _____

Physician's Name & Address: _____

Phone Number/Fax Number: _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Washington Community High School and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (**or to allow my child to self-administer, while under the supervision of the employees and agent 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 OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. The health center staff and/or the school administration may, at their discretion, reject requests for administration of medication. It is understood the school district provides this service in the interest of the well being of students and as an accommodation to parents. In addition, I agree to hold harmless and indemnify that School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

To be completed by parent/guardian

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy as noted above.

For asthma inhalers or epinephrine auto-injectors: I authorize the School District and its employees and agents, to allow my child or ward to self-carry and self-administer his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at school-sponsored activity, (3) while under supervision of school personnel or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30)

Date: _____ Signature: _____ Relationship: _____

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