Dupo School District #196

600 Louisa Ave. Dupo, IL 62239
Jr./Sr. High School Phone 618-286-3812 x 4135 Fax 618-286-5535
Bluffview Elementary Phone 618-286-3311 x 3219 Fax 618-286-4092

Medication Consent Form as required by the State of Illinois

Student

Name of student _____ Date of birth _____
Address _____ Phone # _____ Emergency # _____
School attending _____ Grade _____ School year _____

Medication allergies _____
Daily medications student taking _____

Physician

This medication form is to be filled out by the MD, PA or APN.
Please check and fill in where appropriate if approved for school nurse to administer during school hours.
If applicable, please send Asthma Action Plan and/or Food Allergy Action plan.

Over the counter/Emergency medication:

- ☐ Tylenol _____ mg by mouth q 4-6 hours prn for headache/pain/fever
- ☐ Ibuprofen _____ mg by mouth q 6-8 hours prn for headache/pain/fever
- ☐ Tums _____ mg by mouth once during the school day prn for upset stomach
- ☐ Cough drops one lozenge by mouth every 2 hours prn for cough/sore throat
- ☐ Benadryl _____mg by mouth every _____hours prn for_____
- ☐ Albuterol MDI with Aerochamber 2 puffs every 4-6 hours prn cough/wheezing/chest tightness
- ☐ Epi Pen(0.3 mg)/ Epi Pen Jr. (0.15 mg) 1-2 injectables IM prn food allergy reaction

Prescription:

Name of medication to be given: _____
Diagnosis requiring medication: _____
Dosage/Frequency: _____
Possible length of time to be given: _____
Possible side effects: _____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No
Is it safe for this student to carry an asthma inhaler and/or epi pen and self- administer? ☐ Yes ☐ No

Physician printed name: _____ Office number: _____

Office Address: _____ Fax number: _____

Physician signature: _____ Date: _____

Parents

(See back side)

For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine auto-injector:

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 a school-sponsored activity, (3) while under the 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).

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

_____
Parent/Guardian initials

For all parents/guardians:

By signing below, I agree 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 the School District and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **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 and specifically consent to such practices**, and

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____
Parent/Guardian printed name

Address (if different from Student's above): _____

Phone: _____ Emergency Phone: _____

_____ _____
Parent/Guardian signature Date