Summit Hill School District 161
20100 S. Spruce Drive
Frankfort, Illinois 60423

Administration of Medications in School

Dear Parents and Physicians:

The following is an explanation of our District policy for the administration of any prescription or nonprescription (over-the-counter) drugs during school hours as outlined in School District #161's Handbook of Principles and Procedures with the input by the District 161 Drug Free Committee in compliance with P. A. 86-1441, Public Act 97.0361, Public Act 98.0795 and following the recommendations of the Illinois Office of Education and the Illinois Department of Public Health.

All attempts should be made to schedule medication at home. If medication is required during school hours for the student to remain in school, the parent can choose to either come to school and administer the medicine or complete the district Medication Authorization form so that the medication maybe administered at school.

In order that we can safely administer the medication and for the protection of the student, we require that the physician and parent complete and sign the Medication Authorization Form. *These forms are available from each building secretary.*

Medication should be brought to school by the parent or the parents' designee in a closed container, appropriately labeled by the pharmacist or physician with the student's name, medication, dosage, route of administration, prescription number, pharmacy name and phone number, specific times, date and physician's name and phone number. Discontinuation date of medication should also be indicated on the label.

Consistent with Public Act 97.0361. Asthma inhalers may be carried and self-administered if written authorization is given on the Medication Authorization form *Stu.* 17 by the physician and parent(s).

Consistent with Public Act 98.0795. Epinephrine Auto-Injector may be carried and self-administered if written authorization is given on the Medication Authorization form *Stu.* 17 by the physician and parent(s).

Medications brought to school without the medication authorization from will not be administered. Medications shall be administered under the supervision of the school nurse. The student is responsible for coming to the office for his/her medication. Medications are to be kept at school, not taken back and forth daily except for special authorization noted on *Stu.* 17. The school shall provide a locked space for safe storage of the medication, which is accessible to, authorized personnel only.

The School District and/or its personnel assume no responsibility for any unfavorable reaction to a pupil to medication given upon the request of the parent.

Any changes in medication shall be made only upon the written order of physician and written request of the parent or guardian.

Summit Hill School District #161
Medication Authorization Form

Student's Name:_____ Date:_____

Grade/Teacher: _____ Date of Birth: _____

To be completed by the student's physician:

Name of Medication: _____ Dosage: _____

Frequency: _____ Time to be given at school: _____

Date of Prescription: _____ Discontinuance Date:_____

Diagnosis Requiring Medication: _____

Desired benefits of this medication:_____

Expected side effects, if any:_____

Other medications student is receiving:_____

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

May this medication be safely administered by school personnel other than the school nurse?_____

Physician Authorization for Self-Administration of Asthma Medication or Epinephrine Auto-Injector

In compliance with Public Act 97.0361(July 30, 2014), I authorize this student to carry and self-administer the above mentioned asthma medication. **YES** _____ **NO**_____

In compliance Public Act 98.0795(July 30, 2014), I authorize this student to carry and self-administer the above named epinephrine auto-injector due to risk of anaphylaxis.

YES_____ **NO** _____

_____ _____

Physician's Name – Print Physician's Name – Signature

_____ _____

{Physician's Street/City Address Phone-Office Phone Emergency

(OVER)

To be completed by Parent or Guardian

I hereby confirm 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 Summit Hill School District 161 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer while under the supervision of the employees and agents of the Summit Hill 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, 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, either jointly or severally, from and against any and all claims, damages, causes or action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent's Signature	Date	Parent's Emergency Phone Number

Parent/Guardian Agreement Authorizing Self-Administration of Asthma medication or Epinephrine Auto-Injector

In compliance with Public Act 97.0361 (July 30, 2014) I agree with the doctor statement above to authorize my child to carry and self-administer the above named asthma medication. **YES**_____ **NO**_____

In compliance with Public Act 98.0795 (July 30, 2014), I agree with the doctor statement above to authorize my child to carry and self-administer an epinephrine auto-injector. **YES**_____ **NO**_____

I/We understand that according to state statute the 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 self-administration or use of an epinephrine auto-injector and/or of the asthma medication by my/our child. I/we must 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 self0administration or use of an epinephrine auto-injector and/;or of asthma medication by my/our child. I/we further understand that this permission for self-administration or use of an epinephrine auto-injector and/or of asthma medication is effective for this school year only and must be renewed each subsequent school year if desired. I/we understand that a copy of this permission will be kept in my/our child's medical file.

Parent's Signature	Date	Parent's Emergency Phone Number