Trinity Lutheran School

Self-Administration of Medication (Prescription and Over the Counter)

Physician/Parental Authorization

To be completed by the child's parent(s)/guardian(s) and kept in the school office:

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
Teacher:	Grade:	

To be completed by the student's physician:

Physician's Printed Name:		
Office Address:		
Office Phone:	Emergency Phone:	
Medication:		
Dosage:	Frequency:	
Time medication is to be administered or under what circumstances:		
Prescription date:	Order date:	Discontinuation date:
Diagnosis requiring medication:		
Intended effect of this medication:		
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?	☐ Yes ☐ No	
Expected side effects, if any:		
Other medications student is receiving:_____		
I certify that _____ has been instructed in the use and self-administration of _____.		

_____ _____

Physician's signature **Date**

For parent(s)/guardian(s) of students who have asthma:

I authorize Trinity Lutheran School and its employees and agents, to allow my child or ward to possess and use his or her medication (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 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-administration of medication (105 ILCS 5/22-30).

If you agree please initial:_____

Parent(s)/Guardian(s) initial

By signing below, I agree:

1. 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 Trinity Lutheran School and its employees and agents, in my behalf and stead, to allow my child to self-administer, while under the supervision of the employees and agents of Trinity Lutheran School, lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary at times for the administration of medications to my child to be performed by an individual other than a school nurse in an emergency situation, and specifically consent to such practices**, and

2. To indemnify and hold harmless Trinity Lutheran School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

_____	_____
Parent/Guardian Printed Name	Parent/Guardian Printed Name
_____	_____
Parent/Guardian Signature*/Date	Parent/Guardian Signature*/Date