

**LAKE PARK SCHOOL DISTRICT 108
EMERGENCY/SELF ADMINISTRATION MEDICATION AUTHORIZATION FORM**

STUDENT NAME _____ BIRTHDATE _____

CAMPUS: _____ ID#: _____ PHONE NUMBER _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I, _____, parent or guardian of _____ am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Lake Park School District 108, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of District 108, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. In addition, I hereby consent to any communication deemed necessary by the school nurse with the prescribing physician listed below to discuss the prescription, medication or dosage to be administered pursuant to this School Medication Authorization Form. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Lake Park School District 108, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless Lake Park School District 108, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Start Date: _____ End Date: _____ (Must be renewed each year.)

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

**TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER
FOR EMERGENCY/SELF ADMINISTRATION MEDICATION ONLY**

Student Name: _____ Birth Date: _____

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Purpose: _____

Is it necessary for this medication to be administered during the school day? Yes _____ No _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Special Instructions: _____

Start Date: _____ End Date: _____ (Must be renewed each year.)

Other medications student is receiving: _____

Self-Administration of Epinephrine: ____ Yes ____ No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: ____ Yes ____ No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

Self-Administration of Asthma Medication: ____ Yes ____ No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified healthcare professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Signature of Physician

Phone of Physician

Date

Print Name of Physician

Address of Physician