Students

Exhibit – Medication Authorization Forms

Medication Policy Summary

Administering medication in school is strongly discouraged by Illinois State Law and NDSEC policy. Only medications prescribed by a physician, which are essential for the child to remain in school, shall be given under the conditions described below and with the approval of school administration. It is recommended that parents/legal guardians consult with their doctor to see if midday medication can be adjusted and given at another time.

Medication Authorization Form
For medication given on a regular basis or as needed, a *Medication Authorization* form must be completed by the student's parent/guardian and physician prior to the dispensing of any medication to a student. This authorization form must be renewed at the beginning of each school year. Changes in medication or dosage should be reported immediately and must be authorized in writing by an Illinois licensed prescriber.

Medicine Containers
Medication must be brought to school in the original prescription container with the original pharmacy label affixed with a dispensing date and clearly marked with the student's name, physician's name, medication, dosage and instructions. Over the counter medications (non-prescription) must have the manufacturer's original label with the ingredients listed and the student's name affixed to the container.

Medication That Students Can Carry and Self-Administer
Students may carry and self-administer an asthma inhaler if a completed *Agreement to Carry and Self-Administer Medication* form is completed by the parent and student.

Students may carry and self-administer Epinephrine. A *Medication Authorization* form and *Emergency Action Plan* must be completed by a student's parent/guardian and physician. The physician must define the circumstance under which the medication is to be given. If Epinephrine is given, parents and paramedics will be called for immediate medical follow up.

It is recommended that students who carry and self-administer medication keep "back-up" medication in the health office.

RESUMEN DE LA PÓLIZA DE MEDICAMENTOS

La administración de medicamentos en la escuela esta totalmente desaconsejada por la Ley del Estado de Illinois y la póliza de NDSEC. Solo los medicamentos recetados por un medico, que son esenciales para que el niño permanezca en clase, se realizara bajo las condiciones descritas a continuación y con la aprobación de la administración escolar. Se recomienda que los padres/tutores legales consulten con su médico para ver si el medicamento de mediodía se pude ajustar y dar en otro momento.

Forma de autorización de medicamentos
Para medicamentos administrados de forma periódica o cuando sea necesario, la forma de *Autorización de Medicamentos* debe ser completada por los padres/tutor del estudiante y por el médico, antes de dispensar cualquier medicamento al estudiante. Esta forma de autorización debe ser renovada al inicio de cada año escolar. Cualquier cambio de medicamentos o dosis debe ser reportado inmediatamente y deberá ser autorizado, por escrito, por un médico con licencia en Illinois.

Contenedores del medicamento
Los medicamentos deben ser traídos a la escuela en su envase original con la etiqueta original de la farmacia adherida con la fecha de dispensación claramente marcados y con el nombre del estudiante, del medico, medicamento, la dosis y las instrucciones. Medicamentos de venta libre (no recetados) deben tener la etiqueta original del fabricante incluyendo los ingredientes y el nombre del estudiante pegado al contenedor.

Medicamentos que los estudiantes pueden llevar consigo y auto-administrar
Los estudiantes pueden llevar consigo un inhalador y auto administrarse media vez los padres o tutor completen la forma de *Convenio Para Llevar Consigo y Auto-administrar Medicamento*.

Los estudiantes pueden llevar consigo Epinefrina y auto administrarse media vez los padres o tutor completen la forma de *Autorización de Medicamentos* y el *Plan de Acción de Emergencia*. El médico debe especificar las circunstancias en las cuales el medicamento debe ser dado. Si Epinefrina es administrada, los padres y paramédicos serán llamados para un inmediato seguimiento médico.

Se recomienda que los estudiantes que cargan y auto-administran medicamento dejen medicamento de respaldo *"back-up"* en la enfermería.

Medication Authorization

To be filed at student's school building

Student's Name:				Birth Date:	
Address:					
Parent/Guardian Phone:			Emergency Phone:		
School:		Grade:		Teacher:	

To be completed by the student's physician:

Name of Medication:							
Dosage:		Frequency:		Time to be given in school:			
Date of prescription:		Date of order:		Discontinue/Re-evaluation Date:			
Purpose:				Time Interval for Re-evaluation:			
Diagnosis requiring medication:							
Intended effect of this medication:							
Expected side effects, if any:							
This medication must 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 ☐	
Epinephrine Auto-Injector Only: Student may carry and self-administer:					Yes ☐	No ☐	
Other medications student is receiving:							
Physician's Signature:							
Physician's name (please print)							
Address:							
Office Phone:							
Emergency Phone:							
Date:							

Please use reverse side for further remarks.

I 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 NDSEC 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 NDSEC), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 98-795). **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 NDSEC, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify NDSEC, 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.

Parent(s)/Guardian(s) signature:	
Parent(s)/Guardian(s) name (please print):	
Address:	
Phone:	
Emergency Phone:	
Date:	

MEDICATION AUTHORIZATION

Autorización de Medicamentos

Archivar en el edificio escolar del estudiante. (To be filed at student's building)

Nombre del estudiante:		Fecha de nacimiento:
Dirección:		
Teléfono del Padre/Madre/Guardián:	Teléfono de emergencia:	
Escuela:	Grado:	Maestro(a):

Esta sección debe ser completada por el médico del estudiante (To be completed by the student's physician):

Name of Medication:			
Dosage:	Frequency:	Time to be given in school:	
Date of Prescription:	Date of Order:	Discontinue/Reevaluation Date:	
Purpose:		Time Interval for Re-evaluation:	
Diagnosis requiring medication:			
Intended effect of this medication:			
Expected side effects, if any:			
This medication must 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** ☐	
Epinephrine Auto-Injector Only: Student may carry and self-administer:		**Yes** ☐ **No** ☐	
Other medications student is receiving:			
Physician's Signature:			
Physician's Name: (please print):			
Address:			
Office Phone:			
Emergency Phone:			
Date:			

Por favor use el reverso o adjunte una hoja con más comentarios. (Please use reverse side or attach sheet with further remarks.)

Confirmo que soy la persona principal y responsable de administrar el medicamento a mi hijo(a). Sin embargo, en caso de que yo no pueda administrar el medicamento o en caso de una emergencia médica, por este medio autorizo a NDSEC y sus empleados y agentes, por mi parte y en vez de, administrar o intentar de administrar el medicamento a mi hijo(a) (o permitir a mi hijo(a) que se lo/la administre él/ella mismo(a), bajo la supervisión de los empleados y agentes de NDSEC), el medicamento legítimamente prescrito en la manera que se explica arriba. Esto incluye la administración de auto-inyectores de epinefrina no designadas a mi hijo(a) cuando existe la creencia de buena fe que mi hijo(a) está teniendo una reacción anafiláctica aunque tales reacciones son conocidas por mí o no (105 ILCS 5/22-30, modificado por P.A. 98-795). **Reconozco que puede ser necesario de administrarle el medicamento a mi hijo(a) a través de otra persona aparte de la enfermera escolar y específicamente doy mi consentimiento en tales practicas**. Además reconozco y estoy de acuerdo de, que cuando el medicamento prescrito legalmente es administrado o se intentó ser administrado, yo renuncio a cualquier demanda que yo pueda tener contra NDSEC, sus empleados y agentes que se presenten fuera de la administración del medicamento mencionado. También, estoy de acuerdo de en mantener indemne e indemnizar a NDSEC, empleados y agentes, ya sea colectivamente o respectivamente, de y contra cualquier y todos los reclamos, daños y, las causas por las acciones o heridas incurridas, cometidas o como resultado por la administración o el intento de administrar dicho medicamento.

(I 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 NDSEC 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 NDSEC), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 98-795). ***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 NDSEC, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the NDSEC, 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.)*

Firma del Padre/Madre/Guardián *(Signature)*:	
Nombre del Padre/Madre/Guardián (letra de molde) *(Name):*	
Dirección *(Address)*:	
Teléfono *(Phone)*:	
Teléfono en caso de emergencia *(Emergency Phone)*:	
Fecha *(Date)*:	

Agreement to Carry and Self-Administer Medication

Parent Section:

Student Name:				Birth Date:	
Address:					
Parent/Guardian Phone:			Emergency Phone:		
School:		Grade:		Teacher:	
Physician Name:			Physician Phone:		
Medication:	☐ Inhaler ☐ Epinephrine				
The items below must also be provided:					
☐	Prescription label, which contains the name of the medication, the prescribed dosage, and the time at which or circumstances under which the medications is to be administered. *(Attach to this form)*				
☐	For Epinephrine: Medication Authorization Form and Emergency Action Plan				
******It is recommended that students who carry and self-administer medication keep "back-up" medication at school.***					

Parent Statement:

I authorize the Cooperative 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 Cooperative 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).

Parent Signature Print Name Date

Student Section:

Student Statement:

My signature below indicates my agreement while I am at school or school activities to the following:

- I have demonstrated the correct administration of the above-listed medication to the School Nurse.
- I agree to never share my medication with another person.
- I agree if there is any problem or lack of desired effects in or after use of the medication, I will notify a teacher or other school staff member for assistance or notification of my parent/guardian and School Nurse.

Student Signature Print Name Date

CONVENIO PARA LLEVAR CONSIGO Y AUTO-ADMINISTRAR MEDICAMENTO

Sección Para los Padres:

Nombre del estudiante:		*Fecha de nacimiento*:	
Dirección:			
Teléfono del Padre/Madre/Guardián:		*Teléfono de emergencia*:	
Escuela:		*Grado*:	*Maestro(a)*:
Nombre de su Medico:		*Telefono de su Medico:*	
Medicación:	☐ Inhalador ☐ Epinefrina		
Lo siguiente también debe ser proporcionado:			
☐	La etiqueta de la receta, que contiene el nombre del medicamento, la dosis prescrita, y la hora en que o las circunstancias en las que el medicamento se debe administrar. *(Adjunte con esta forma)*		
☐	Para Epinefrina: Formulario de Autorización de Medicamentos y el Plan de Acción para Emergencias		
****** Se recomienda que los estudiantes que lleven consigo y auto administran medicación mantengan medicamento de respaldo "back-up" en la escuela.***			

Declaración de los Padres/Guardián:

Yo autorizo a la cooperativa y sus empleados y agentes, que permitan a mi hijo(a) o pupilo llevar consigo mismo(a) y auto administrarse su medicamento del asma y/o auto inyector de epinefrina: (1) mientras en la escuela, (2) mientras en una actividad escolar, (3) mientras bajo la supervisión del personal escolar, o (4) antes o después de actividades escolares normales, tal como mientras en cuidado antes de la escuela o después de la escuela ubicado en propiedad escolar. La ley de Illinois requiere que la cooperativa informe a los padres / tutor legal que la cooperativa y sus empleados y agentes, no incurren ninguna responsabilidad, con excepción de conducta deliberada y sin motivo, como resultado de cualquier lesión que surja de un estudiante que lleve consigo mismo y se auto administre medicamentos del asma o auto inyector de epinefrina (105 ILCS 5/22-30).

Firma del Padre/Madre/Guardián Nombre (letra de molde) Fecha

Sección del Estudiante:

Declaración del Estudiante:

Mi firma abajo indica que estoy de acuerdo que mientras estoy en la escuela o actividades escolares a lo siguiente:

- He mostrado la administración correcta del medicamento mencionado arriba a la enfermera de la escuela.
- Me comprometo a nunca compartir mi medicamento con otra persona.
- Estoy de acuerdo si hay algún problema o falta de efectos deseados durante o después del uso del medicamento, voy a notificar a un maestro(a) u otro miembro del personal escolar para que me ayude o para notificar a mi padre/madre/guardián y enfermera escolar.

Firma del Estudiante Nombre (letra de molde) Fecha

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