

GENOA-KINGSTON C.U.S.D. # 424

Epipen Physician Request For Self-Administration of Medications

_____/_____/_____
Name of Student D.O.B.

Address

_____(_____)_____
City Zip Telephone

The above named student has

Name of Condition or Disease

I am requesting that the above named student take the following medication during school hours.

Name of Medication Type of Medication

Dosage Time of Administration

Possible Side Effects

I certify that _____ has been instructed in the use and
Student's Name

self-administration of _____,
Medication

and to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

I may be reached at the following phone # in the event of an emergency:

Signature of Physician/Date Address of Physician

Printed Name of Physician Phone Number of Physician

2010 - 2011

Ref: Illinois Department of Human Services and Illinois State Board of Education "Recommended Guidelines for Medication Administration in Schools"

GENOA-KINGSTON C.U.S.D. # 424
980 Park Avenue Genoa, IL 60135

Genoa-Kingston School District has received your request for self-administration

of _____,

for your child _____.

State Law requires that we inform the parents or guardians of the student, in writing, that the school district and it's employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

Before your child _____ will be allowed to self-administer the medication, you must first sign and return a copy of this document.

The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year.

A student with bee sting/peanut allergy may possess and use his/her medication while in school, at a school sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before-school or after-school care on school operated property. We do recommend you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his/her medication.



I _____ parent/guardian of

_____, acknowledge that Genoa-Kingston C.U.S.D. # 424 and it's employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. I indemnify and hold harmless the school district and it's 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 student.

Parent Signature and Date

Witness Signature and Date

2010 – 2011

School Copy

Ref: Illinois Department of Human Services and Illinois State Board of Education "Recommended Guidelines for Medication Administration in Schools"

**GENOA-KINGSTON C.U.S.D. # 424
2010 - 2011**

Parent Agreement for Student to Carry Medications

I give my permission for

to carry the medication described below. I will notify the school nurse of any changes of medication or my child's condition.

Name of Medication	Dose	Times of Administration
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Parent/Guardian
Signature _____

Date _____

GENOA-KINGSTON C.U.S.D. # 424
980 Park Avenue Genoa, IL 60135

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I _____ parent/guardian of

_____,
acknowledge that Genoa-Kingston C.U.S.D. # 424 and its employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the above named student. I 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 self-administration of medication by the student.

Parent Signature and Date

Witness Signature and Date

2010 - 2011
Parent Copy

Ref: Illinois Department of Human Services and Illinois State Board of Education "Recommended Guidelines for Medication Administration in Schools"