

**MEDICATION ADMINISTRATION/SELF-ADMINISTRATION**  
**CONSENT FORM FOR PRESCRIPTION AND**  
**OVER-THE-COUNTER MEDICATIONS**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

**Part I – Physician’s Statement** *(This statement may be signed by a physician’s assistant or advance practice registered nurse having such authority delegated by a supervising/collaborating physician.)*

***Narcotics may not be taken prior to or during school hours.***

1. Name/type of medication: \_\_\_\_\_
2. Is the prescribed medication for an asthmatic condition? \_\_\_\_\_
3. If the prescribed medication is an epinephrine auto-injector, is the device for immediate self-administration by a person at risk of anaphylaxis? \_\_\_\_\_
4. Dosage/amount to be given: \_\_\_\_\_
5. Route of administration: \_\_\_\_\_
6. Frequency and time of administration, or special circumstances under which the medication or epinephrine auto-injector is to be administered: \_\_\_\_\_
7. Duration (e.g., week, month, indefinite): \_\_\_\_\_
8. Diagnosis, intended effect and anticipated reaction to medication (symptoms, side effects, etc.):  
\_\_\_\_\_
9. Other medication student is receiving: \_\_\_\_\_
10. Other requirements or special circumstances: \_\_\_\_\_
11. Must this medication be administered during the school day in order to allow the student to attend school? \_\_\_\_\_
12. Is supervised student self-administration authorized? \_\_\_\_\_
13. **For asthma medication or epinephrine auto-injector only\*** -- Is unsupervised self-administration authorized? \_\_\_\_\_

***\*Pursuant to Illinois law, upon parental consent, a student who is prescribed asthma medication or an epinephrine auto-injector may possess and use his/her asthma medication or epinephrine auto-injector during school or at school-sponsored activities without the supervision of district personnel.***

\_\_\_\_\_  
(Physician’s Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone Number)

**Part II– Liability Notice**

Community High School District 117 and its 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 or use of an epinephrine auto-injector by the student.

[Please complete form and fax to Nurse at ACHS Health Office: 847-838-7686]

**PARENTAL CONSENT FORM**  
**EMERGENCY TREATMENT**

I, \_\_\_\_\_, parent/legal guardian of \_\_\_\_\_, have enrolled my child in and hereby authorize Dr. \_\_\_\_\_, my child's physician, or any physician in his or her group practice, on my behalf to administer emergency medical assistance to my child during school or a school-sponsored activity. In the event my child's physician, or any physician in his or her group practice, is not available, or contact with my child's physician is not practical under the circumstances, I hereby authorize Community High School District 117, its employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for my child whenever the authorized school personnel believe such emergency medical assistance is necessary to protect the health, safety and welfare of my child. I further waive any claims against Community High School District 117, the members of the Board of Education, its employees and agents arising out of the provision of or arrangement for emergency medical assistance to my child and agree to hold harmless and indemnify Community High School District 117, the members of its Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the provision of or arrangement for emergency medical treatment.

Signed \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

**Part III- Parent's Request/Approval**

I hereby request and grant permission for Community High School District 117 school personnel to [***check one***] \_\_\_\_\_ administer or \_\_\_\_\_ permit the self-administration of medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I acknowledge that Community High School District 117 is to incur no liability, except for willful and wanton conduct, arising from the self-administration of medication or use of an epinephrine auto-injector by my daughter/son. I further waive any claims against the School District, members of the Board of Education, its employees and agents arising out of the administration or self-administration of said medication or use of an epinephrine auto-injector, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication or use of such epinephrine auto-injector. With respect to student self-administration of asthma medication or use of an epinephrine auto-injector, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

**For asthma medication or epinephrine auto-injector only** – I consent to my child's possession and unsupervised self-administration of asthma medication: \_\_\_\_\_ yes \_\_\_\_\_ no. I consent to my child's possession and unsupervised use of his/her epinephrine auto-injector: \_\_\_\_\_ yes \_\_\_\_\_ no.

Signed \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_