Edgar County CUSD #6
School Prescription Medication Policy

Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parents/guardians believe that it is necessary for the student to take a medication during school hours or school-related activities, the parent/guardian must request that the school dispense the medication to the child and otherwise follow the District's procedures on dispensing medications.

No school district employee shall administer to any student or supervise a student's self administration of any prescription or non-prescription medication until a completed a signed School Medication Authorization Form is submitted by the student's parent/guardian. No student shall possess or consume any prescriptions or non-prescriptions medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures.

Provided the student's parent/guardian has completed and signed a School Medication Authorization Form, a student may possess an epinephrine auto-injector (Epi-pen) and/or medication prescribed for asthma for immediate use at the student's discretion. The school district shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication, or epinephrine auto-injector, or the storage of any medication by school personnel.

Nothing in this policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

Legal Ref.: 105 ILCS 5/10-20.14b, 5/10-22.21b and 5/22-30

Prescriptive Procedures and Medication Guidelines

1. The School Medication Authorization Form must be **completed and signed by a doctor**. (Parent/guardian will be responsible for acquiring the doctor's signature.)

2. The School Medication Authorization Form must also be **signed by a parent/guardian**.

3. All medications must be in an original pharmacy labeled container with the student's name, current date, name of medication, dosage, and time to be given.

4. The school retains the right to approve or deny any request.

5. Parents/guardians may choose to come to school and administer medication to their child.

Edgar County CUSD #6
School <u>Prescription</u> Medication Authorization Form

<u>This section to be completed by the student's parent/guardian</u>
Student:_______________________________ Birth date:__________ Phone:_______________
Address:____ Alt. Phone:________________

<u>This section to be completed by the student's physician</u>
Medication prescribed:_________________________ Dosage________ Frequency__________
Time to be administered and 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 child's medical condition? ❑Yes ❑No
Expected side effects if any:____
Other medications student is receiving:____
Permission for student to self-administer? ❑Yes ❑No

Physician's Printed Name: ____
Office address:____
Office phone:_____________________

Physician Signature____ Date ______________

For parents/guardians of students who have ASTHMA: I authorize the Edgar County CUSD #6 and its' employees and agents, to allow my child to possess and use his/her asthma medications (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. Illinois law requires the school district to inform parents/guardians 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 (105ILCS 5/22-30)
If you agree please initial:______ (Parent/guardian 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 the Edgar Co. CUSD #6 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 the school district), lawfully prescribed medication in the manner described above. **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,** and
2. To indemnify and hold harmless the Edgar Co. CUSD #6 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/guardian signature Date