2019/2020 School Yr.

AJCHS DISTRICT 81

608 S. MAIN ST. | ANNA, IL. 62906

Dear Parent or Guardian,

My name is Brooke Frank, and I am your child's school nurse! First and foremost, I am looking forward to getting to know you and your child throughout the school year. I also want to remind you of some very important rules and regulations regarding the care I will be providing your child throughout the school year.

As in the past, **all medications given at school** (prescription and non-prescription) **require a completed parent and physician consent form on file at school before medication can be administered.** This includes medications such as Ibuprofen, Tylenol, Aleve, Benadryl, Asthma Inhalers, etc. The required forms are attached to this newsletter and must be filled out by both you and your child's physician and returned to the nurse's office before your child can receive medication at school.

This policy follows the Illinois State Board of Education guidelines and the Illinois Department of Human Services guidelines.

Please read and complete the parent section of the form and have your child's doctor complete the other side and return it to the school. Remember, <u>any medications (including over-the-counter medications) cannot be allowed or administered unless both consents are on file at the school.</u>

Sincerely,

BROOKE FRANK, RN
SCHOOL NURSE

2019-2020 Parent Consent for Medication Administration

Student Name | Date of birth | Grade

Physician Name | Physician Address | Physician Phone #

Please read the following medication administration guidelines:

1) Medication Administration Form for all prescription and non-prescription medications must be authorized/signed/completed by student's doctor and on file at the school
2) Immediate notification of any changes must be submitted in writing by the prescribing provider/doctor
3) Medication must be in the original labeled container as it was when it was dispensed
4) Medication label must contain student's name, date, name of medication, dosage, directions for use, as specified by doctor/provider on the consent form
5) Over-the-counter medications must be in the original unopened container with the student's name on the container.

I hereby acknowledge 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 AJCHS District 81 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of AJCHS District 81) lawfully prescribed medication in the manner described above and as indicated on the physician administration form. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse, and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or separately, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

Parent Signature | Date

If student uses prescribed inhaler:
My child has been instructed in the use of the prescribed inhaler. I give permission for my child to carry and use the prescribed inhaler at school.

Parent Signature | Date

Anna-Jonesboro Community High School
District 81

Authorization and Permission for Administration of Medication

Student's Name ______________________ Birthdate ______________________

School ______________________ Date ______________________

School medications and health care services are administered following these guidelines:

Physician/prescriber signed authorization to administer the medication.
Parent signed, dated authorization to administer the medication.
The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
The medication label contains the student name, name of the medication, directions for use and date.
Annual renewal of authorization and immediate notification, in writing, of changes.

Physician Authorization:

Medication/Health Care Treatment ______________________ Dosage ______________ Time to be Administered ______________

Intended effect of this medication ______________________ Expected side effects, if any ______________________

Other medications student is taking ____

____

May student self administer medication under supervision of Health Service personnel or designate? (A student self-administration form must be completed)

(Please circle) **Yes or No**

Administration Instructions

____

____

Discontinue/Re-evaluation/Follow-up Date (circle one) ______________________

Prescriber's Signature ______________________ Date Signed ______________________

Prescriber's Emergency Phone # ______________________ Prescrber's Address ______________________

____

Anna-Jonesboro Community High School
District 81

Physician Request for Self-Administration of Medication

Name of Student ____________________	Birthdate ____________________
City ______________ Zip ______	Telephone Number ____________________

To:

Principal: ____________________

School: ____________________

The above named pupil has ____
(Name of Disease or Syndrome)

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

Name of Medication ____________________	Type of Medication (Tablet, Liquid, Capsule) ____________________
Dosage ____________________	Time(s) to be given ____________________

Possible Side Effects ____

I certify that ______________________________ has been instructed in the
Name of student

use and self-administration of ______________________________.
(Name of Medication)

He/she understands the need for the medication, and the necessity 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 a reaction to the medication or emergency:

Phone number of Physician ____________________	Signature of Physician ____________ Date ______
Address of Physician ____________________	Print Name of Physician ____________________