MEDICATION AUTHORIZATION FOR STUDENTS WITH A LIFE-THREATENING ALLERGY

SELF CARRY-SELF ADMINISTER WITHOUT SUPERVISION

WOODRIDGE SCHOOL DISTRICT 68

Student Name: _____

School: _____ **Grade:** _____ **Birth Date:** _____

Phone Number: _____ **Emergency Number:** _____

I authorize Woodridge School District 68 and its employees and agents, to allow my child or ward to possess and use his/her medication: **(1)** while in school, **(2)** while at a school-sponsored activity, **(3)** while under the supervision or school personnel, or **(4)** before or after normal school activities, such as while in before-school or after-school care on school-operated property. My child's physician has indicated that my child is capable of self-administration of his/her medication. I will notify the school of changes in the medication or changes in my child's condition. I understand that this permission for self-administration of medication is only effective for the current school year and will need to be renewed each subsequent school year.

Illinois law requires the Woodridge School District 68 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/self-administration of medication.

Parent/Guardian Signature: _____ **Date:** _____

TO BE COMPLETED BY THE PHYSICIAN

LIFE THREATENING ALLERGY TO: _____ **MEDICATION:** _____

DOSAGE: _____ **SIDE EFFECTS:** _____

DATE OF PRESCRIPTION: _____ **EXPIRATION DATE:** _____

_____ has a life-threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. It is medically necessary for him/her to always carry an auto injector device. The student has been instructed in the self-administration of the above mentioned medication and is capable of doing this independently. **The student understands the necessity of notifying a staff member and the health office immediately following the self-administration of an Epi-Pen auto injector.**

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____ _____

Phone Number of Physician | Signature of Physician | Date

_____ _____

Address of Physician | Print Name of Physician