

CONTRACT FOR SELF-ADMINISTRATION OF MEDICATION

PAWNEE COMMUNITY UNIT SCHOOL DISTRICT #11

PHONE: 625-2471

FAX: 625-2251

STUDENT'S NAME _____ Grade _____ Date of Birth _____

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The following section is to be completed by the STUDENT:

I agree to never share my EPI PEN or inhaler with another person and I will use it only as prescribed and instructed by my doctor. I will tell the teacher, school nurse, or other responsible adult if I need to use it or have used it or if I have any allergy related symptoms.

Student's signature Date

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The following section is to be completed by the PARENT:

I give my permission for _____ to carry an EPI PEN or inhaler and self-administer the medication as described below. I understand that self-administer means that he/she has the discretion as to the use of the medication. By signing below I authorize the Pawnee School District and its employees and agents to allow my child or ward to possess and use his/her medication while in school, at a school sponsored activity, and before or after normal school activities. The Pawnee School District and its employees and agents incur no liability, except for willful and wanton conduct, as a result of an injury arising from a student's self-administration of medication. I agree to indemnify and hold harmless the Pawnee School District and its employee and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child. (Legal reference 105 ILCS 5/22-30). I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

Parent/Guardian Signature Date

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The following section is to be completed by the PHYSICIAN:

NAME OF MEDICATION _____

DOSAGE _____ INSTRUCTIONS FOR USE _____

DIAGNOSIS for which medication is intended _____

SPECIAL INSTRUCTIONS _____

I certify that the above name pupil has been instructed in the use of self-administration of the above named medication. He/she understands the need for medication and necessity to report to school personnel any unusual symptoms regarding his allergy. He/she is capable of carrying and using this medication independently.

Physician Signature Date Phone Fax