RANTOUL TOWNSHIP HIGH SCHOOL
DISTRICT # 193
FAX # 217-892-6181 or
 # 217-892-6182

SELF-ADMINISTRATION OF ASTHMA MEDICATION, INSULIN, or EPINEPHRINE AUTO-INJECTOR AUTHORIZATION FORM

_______________________________ ____/____/______ __________ ___________
Student's Name Birth Date Grade Date

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

1. **Physician/prescriber signed and dated authorization to administer the medication**
2. **Parent/guardian signed and dated authorization to administer medication**
3. **The medication must be in the original labeled container as dispensed or the manufacturer's labeled container.**
4. **The medication label must contain the student's name, name of the medication and directions for the use and date.**
5. **Annual renewal of authorization and immediate notification of changes is required.**

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TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE REGISTERED NURSE

Medication:_________________________ Dosage:___________________________ Time to be administered: ______________

Diagnosis:__________________________ Side Effects (if any):_______________________

Effective Date:___________________ To: ___________________

Other Medication Student is Taking: ____________________________________

May the student self-administer the medication under the supervision of a school nurse or school designee? ____ YES ____ NO

As a Healthcare provider for the above named student, I certify that she/he has been instructed in the use and self-administration of the above named medication and the necessity to report to school personnel any unusual side effects. She/he is capable of using this medication independently.

____ ____________________________ _______________
Name of Physician, Physician Assistant or Advanced Practice Nurse Signature Date

Office Phone: _________________________________ Address: ______________________________________

For only Parent(s).Guardian(s) of students requiring asthma inhalers and/or epinephrine injectors:

Is the asthma inhaler and/or epinephrine injector required under a qualifying plan pursuant to 105 ILCS 5/10-22.21b, amended by P.A. 101-205, eff. 1-1-20?

______ YES ______ NO

Please continue to other side

For all Parent(s)/Guardian(s):

By signing below, I agree 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 Rantoul Township High School and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law while under supervision of the employee and agents of District # 193), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and agree to indemnify and hold harmless Rantoul Township High School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the child's self-administration of medication.

_____ _____

Phone # Emergency Phone #

_____

Parent/Guardian printed name

_____ _____

Parent/Guardian signature Date

Asthma Inhalers

I authorize Rantoul Township High School and its employees and agents, to allow my child or ward to carry and self-administer his/her asthma inhaler and/or use his/her epinephrine auto-injector: (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, such as while in before-school or after-school care on school-operated property. Illinois law requires Rantoul Township High School 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-administration of asthma medication or epinephrine auto-injector (105 ILCS5/22-30)

Please initial below to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his/her asthma medication or epinephrine auto-injector.

_____

Parent/Guardian initials

I CHOOSE TO SUBMIT A PRESCRIPTION LABEL: _____ YES _____ NO

(If you have chosen NOT to submit the prescription label, your child's healthcare provider must complete the front page.)

PLEASE NOTE: For a rescue/reliever inhaler the Parent/Guardian may choose to provide the school with a current prescription label instead of a written doctor's order. The label **MUST** contain the name of medication, the prescribed dosage, and the time at which or circumstance under which the medication is to be administered.

Place label here

Student Authorization:

I agree to:

- Demonstrate correct use of the inhaler, syringe and/or Epinephrine auto-injector using a trainer/demonstrator to the registered nurse at school.
- Never share the inhaler, syringe or Epinephrine auto-injector with another person.
- Notify a teacher or other responsible adult if there is not marked improvement in my breathing or Hypoglycemia/Hyperglycemia symptoms within several minutes of using an inhaler or administering insulin or snack.
- Immediately notify a teacher or another responsible adult if I use my Epinephrine auto-injector.

Student Signature: _____ Date: _____