CENTRAL
UNIT SCHOOL DISTRICT 301

Department of Student Services – Health Services Division

Dear Parents / Guardians:

To comply with the mandates of the state of Illinois, medications will be administered in school only when a Med A form has been completed by the parent / guardian or an emancipated student *and* the healthcare provider. Medications are defined as either prescription or over-the-counter products that have any medicinal ingredients whatsoever. In District 301, specialized forms exist for epinephrine and for medicines to treat asthma, diabetes, and seizures; the attached Med A form is not the correct form in these situations; please access the respective packet on the District website or ask the building nurse.

If you feel your child may require a prescription or over-the-counter medication during school, on either a daily or an as needed basis, there must be a Med A form completed. One form must be completed for each medication. Once the document is complete and filed in the school health office, the identified medication may be administered to the student. The order for medication and thus the Med A form must be renewed by the healthcare provider / physician annually or every time a medication or dosage is changed.

The medication provided to school must precisely match the medication the healthcare provider listed on the Med A form. All medications need to be delivered to school by an adult. Students are not permitted to transport medications to school, nor back home. Exceptions are epinephrine and asthma medications if self-administration forms have been completed; see the Asthma or Allergy packets on the district website for further directions.

These procedures are for the protection of all students in District 301. A complete Guideline for Medication Administration in Illinois schools can be found on the Illinois State Board of Education website. The District guidelines are in the student handbooks. We appreciate your cooperation with this process as we believe it benefits both you and your child in knowing that medications are being safely administered. If you have any questions, please feel free to call.

Respectfully,

Central CUSD 301 Health Department Staff

	CHS	CMS	PKMS	HBT	CT	PV	LL
phone	847-464-6030	847-464-6000	847-717-8100	847-464-6008	847-717-8000	847-464-6014	847-464-6011
fax	847-464-6039	847-464-0233	847-717-8105	847-464-6022	847-717-8006	847-464-6024	630-387-7912

Kane County Health Department

KANE COUNTY MEDICATION AUTHORIZATION FORM

NOTE: In D301, this is not the form for asthma, severe allergic reactions, not seizures;
For the proper paperwork: see Chronic Health Conditions on the website. www.central301.net

Student's Name: _____ Birth date: _____ School Year: _____
Address: _____ District: _____
School: _____ Grade/Teacher: _____

I hereby confirm primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Central Community School District (CCUSD) 301 and its employees and agents, on my behalf and stead, to administer, or to attempt to administer, to my child, lawfully prescribed medication in the manner described below.

I acknowledge that it may be necessary for the principal and school administration to assign the dispensing of medications to my child to an individual other than a school nurse, and specifically consent to such practices.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, or attempted to be administered, I waive any claims I might have against CCUSD 301 its employees and agents, either jointly or severally, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, or attempt at administration, of said medication. CCUSD 301 Staff (specify if desired _____ may contact the prescribing healthcare provider for my child when deemed necessary.

_____ _____ _____
Parent/Guardian Signature **Print Name** **Date**

TO BE COMPLETED BY THE STUDENT'S HEALTHCARE PROVIDER FOR ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATION:

Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition? YES NO

Name of medication: _____

Dosage:_____

Frequency:_____

Route: _____Time to be given in school:_____

Diagnosis requiring medication:

Intended effect of this medication: _____

Side Effects: _____

Start Date of Prescription: _____ End Date of Prescription: _____

Other medications the student is receiving:

Special Instruction: _____

_____ _____ _____
Healthcare Provider Name—Print **Healthcare Provider Name—Signature** **Date**

Print (or stamp) Name and Address of Prescriber:

_____ Telephone Number: _____

_____ Fax Number: _____

_____

	CHS	CMS	PKMS	HBT	CT	PV	LL
phone	847-464-6030	847-464-6000	847-717-8100	847-464-6008	847-717-8000	847-464-6014	847-464-6011
fax	847-464-6039	847-464-0233	847-717-8105	847-464-6022	847-717-8006	847-464-6024	630-387-7912

rev2018.4