WINFIELD SCHOOL DISTRICT 34

Winfield Primary School 0S150 Winfield Road, Winfield, IL 60190
Winfield Central School 0S150 Park Street, Winfield, IL 60190

Dear Parent/Guardian,

In 2002, the Board of Education adopted a revised policy on medications in schools. The purpose of this policy is to comply with revised Illinois guidelines for medication administration, to protect all children from unsafe drug practices, and to provide a drug free environment. It is not the intention of this policy to make it difficult for children to receive necessary medication while at school. This policy applies to both normal school hours, as well as any extra-curricular activities that your child maybe participating in.

- All medications, **prescription** and **non-prescription**, to be administered at school must have the attached form completed and signed by the doctor **and** parent.
- **Non-prescription medication includes aspirin, Tylenol, Ibuprofen, cough medication, cough drops, eye drops, creams, ointments, vitamins, and any other medication that can be obtained without a doctor's order**.
- The attached form can be faxed by the doctor (630/260-2382 Primary or 630/933-9236 Central); however for the school to dispense medication, the attached form must be completed by both the doctor and the parent.
- All prescription medication must be in its original container.
- A new form is required for every school year.

PLEASE NOTE: A student may possess medication prescribed for asthma or allergies (inhalers/epi-pens) for immediate use at the students' discretion. Both the doctor and parent/guardian must complete and sign a "School Medication Authorization Form" for an epi-pen. Physician orders or a photocopy of the pharmacy label for the asthma medication is acceptable and must be on file with the nurse.

Remember that this form must be signed by the doctor and by the parent. You might want to bring a copy of this form to your doctor's office to be kept on file there.

If there are any questions regarding this policy, please feel free to call. Our intention is to handle each situation considerately, with the student's best interest in mind.

Thank you for your cooperation.

Sincerely,

Matt Rich

Matt Rich, Ed.D.
Superintendent

Matt Rich, Ed.D.
Superintendent
630.909.4900 TEL
630.260.2382 FAX

Dawn Reinke
Principal
630.909.4960 TEL
630.933.9236 FAX

Visit us at www.winfield34.org

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SCHOOL MEDICATION AUTHORIZATION FORM

To be completed by the child's parent(s)/guardian(s) and physician, to be kept in the school office:

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

Grade: _____ Teacher: _____

To be completed by the student's PHYSICIAN:

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____

Medication:

_____

_____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

Diagnosis requiring medication: _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? ☐ Yes ☐ No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____ _____

Physician's signature **Date:**

(continued ….)

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To be completed by the student's PARENT/GUARDIAN:

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 the School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices**, and
- To indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

Parent/Guardian (please print)	Parent/Guardian (please print)
Parent/Guardian **Signature*** **Date**	Parent/Guardian **Signature*** **Date**

**** Both parents and/or guardians, if available, should sign.***

For parent(s)/guardian(s) of students who have asthma/severe allergies:

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma/allergy medication (inhaler/epi-pen) (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 the School District 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 medication (105 ILCS 5/22-30).

If you agree please initial: _____
Parent(s)/Guardian(s) initial

Winfield Board of Education
Board Policy September 2001 7:270-E

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