REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL
Edwardsville Community Unit School District #7

The Following Applies to Diabetes, Severe Allergy, and Asthma

For students with Diabetes, the licensed prescriber must indicate 'yes' or 'no' below and approve and sign the student's Diabetes Care Plan developed by their health care provider.

Self-administer insulin: _____**NO**

_____**YES,** I have determined that it is medically necessary for this student to carry their diabetes care medicine and supplies. The student has been instructed to the self-administration of the above mentioned medication and is capable of doing this independently. The student understands that if after treating their hypoglycemia or hyperglycemia they do not experience a marked improvement in their condition, they must immediately see the nurse, school employee designated to administer medication, or other adult supervisor.

____ _____________________
Licensed Prescriber Signature Date

____ _____________________
Licensed Prescriber name (Print) Phone

____
Address

For students with Severe Allergy, the licensed prescriber must indicate 'yes' or 'no' below

Self-administer epinephrine:_____**NO**

_____**YES,** I have determined that it is medically necessary for this student to carry an epinephrine auto-injector. The student has been instructed to the self-administration of the above mentioned medication and is capable of doing this independently. The student understands the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

____ _____________________
Licensed Prescriber Signature Date

____ _____________________
Licensed Prescriber name (Print) Phone

____
Address

For students with Asthma, the **PARENT/GUARDIAN** must indicate 'yes' or 'no' below

Self-administer inhaler: _____**NO**

_____**YES,** I give permission for my student, ______________________________, to carry an inhaler and to self-administer the medication as prescribed by their physician. My student's physician has instructed my student in the self-administration of their medication and has indicated that my student is capable of doing this independently. My student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

_____**YES,** I have provided a label containing the name of medication, the prescribed dosage, and the time at which or circumstances under which the medication is to be administered.

____ _____________________
Parent/Guardian Signature Date

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Edwardsville Community Unit School District #7

STUDENT AGREEMENT TO COMPLY WITH THE RULES FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION, EPINEPHRINE MEDICATION, AND DIABETES MEDICATION AND EQUIPMENT

I,____, am a student enrolled in Edwardsville Community Unit School District No. 7. I further state that I have been prescribed medication to address my asthma/life threatening allergy/diabetes by a qualified health care professional. I hereby agree to comply with the following rules for self-administration of medication and use of medication equipment at school:

1. I will demonstrate proper use of the prescribed medication and equipment to the school nurse or other school employee designated to administer medication prior to possessing and self-administering the medication at school.

2. I will take care to keep my medication and equipment in my possession and under my control at all times.

3. I will never share my medication or equipment with another individual.

4. If I do not experience a marked improvement in my condition after two puffs of a prescribed inhaler, I will immediately see the nurse, other school employee designated to administer medication or adult supervisor for further assessment of my condition; or

   After self-administering my epinephrine medication, I will immediately contact the nurse, other designated school employee or adult supervisor so they may call 911 and monitor my condition; or

   If after treating my hypoglycemia or hyperglycemia I do not experience a marked improvement in my condition, I will immediately see the nurse, school employee designated to administer medication, or adult supervisor for further assessment of my condition.

I understand that, if I am found abusing my medication or using it improperly, my parent/guardian will be notified, and I may lose the ability to self-administer my medication at school.

Student Signature:____ Date:____________

Parent/Legal Guardian Signature: ____ Date: ____________