# WILLOWS ACADEMY

## ***SELF-ADMINISTRATION OF PRESCRIPTION ALLERGY MEDICINE/EPI PEN PERMISSION FORM /OTHER MEDICATIONS***

Policy Statement for Willows Academy – School year 2020-21

Dear Parent/Guardian,

State Law requires that we inform the parents/guardian of the student, in writing, that the school and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of prescription allergy medication /EPI Pen medication / other prescription medication by the student (Prescription Medication).

In order for students to self-administer, either auto-injectable epinephrine or inhaled asthma medication, a written **Physician's Statement** must be received by Willows Academy detailing the name of the medication, method, amount and time schedules by which the medication is to be taken, and confirmation that the student is able to self-administer either the auto-injectable epinephrine or the inhaled asthma medication.

The permission for self-administered Prescription Medication is effective for the school year for which it is granted and **must be renewed each school year**. A student with allergies or other medical condition may possess and use her medication while in school, at school-sponsored activities, while under the supervision of school personnel, or before or after regular school activities. We recommend that you provide an additional dose of medication to be kept at school in the event that your child forgets or loses the medication.

**READ, SIGN BELOW AND RETURN THIS FORM via email to (healthforms@willowsacademy.org)**

I, _____Parent/Guardian of _____ acknowledge that Willows Academy and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of allergy medicine, Diabetes Medication, Other Medications by the above named student. I indemnify and hold harmless Willows Academy and its employees and agents against any claims arising out of self-administration of allergy medication, Diabetes Medication, Other Medications by the student.

**SIGNED:**_____ **DATE:** _____

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I give permission for my child, _____, to carry allergy medication/Epi pen/Diabetes Medication/Other Medication as ordered by her physician. I will notify the school of changes in medication or my child's condition.

**Parent/Guardian Signature:** _____ **Date:** _____

_____ _____

**Name of Student** **Date of Birth**

_____ _____

**Address** **City** **Zip** **Phone**

**Authorization and Release**
**Regarding Student Self-Administered Medication**
**(Auto-Injectable Epinephrine, Diabetes Medications, Other Medications)**

Name of Student: _____

Date of Birth:_____

School of Attendance: _**WILLOWS ACADEMY**_____ 20-21 Grade:_____

Authorizing Physician:_____

Physician's Phone:_____ Address:_____

I, _____, am the parent, foster parent, or legal guardian of the above referenced student enrolled in Willows Academy ("the school") and I am legally authorized to provide this Authorization and Release.

**Consent for Student to Self-Administer**

I hereby consent to my child's carrying and self-administration of auto-injectable epinephrine/Diabetes Medication/Other Medications. I understand that this consent is effective only if my child's physician has provided a written statement which details the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirms that my child is able to self-administer auto-injectable epinephrine/Diabetes Medication/Other Medication. The Physician's Statement form is attached to this Authorization and Release.

**Authorization to Consult with Health Care Provider**

I hereby authorize the school to consult with my child's health care provider (physician or physician's staff) listed above regarding any questions that may arise with regard to the following medication: _____.

**Release of Liability**

I hereby expressly release and hold harmless Willows Academy, its officers, employees and agents from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication.

**General**

I understand that this Authorization and Release is only valid for 2020-2021 (current school year). I am required to provide a new Authorization and Release, and accompanying Physician's Statement, each new school year in order to allow my child to self-administer medication. I am also required to provide a new Authorization and Release form if the medication, dosage, frequency of administration, or reason for administration changes. I also understand that my child will be subject to disciplinary action, including suspension or expulsion, if she uses the auto-injectable epinephrine/Other Medications in a manner other than prescribed, and have explained this to him/her.

I understand and agree to all of the statements above. I have had all of my questions answered by the school and hereby willingly provide this Authorization and Release.

Parent, Foster Parent, Guardian Signature: _____

Date: _____

## PHYSICIAN'S STATEMENT: (To be completed by student's physician for Student Self-Administration of Medication)

Name of Student: _____

Date of Birth:_____

School of Attendance: _**WILLOWS ACADEMY**_____ 20-21 Grade:_____

Authorizing Physician:_____

Physician's Phone:_____ Address:_____

**The above named student has the following condition(s):**

**_____**

**I, _____, am the Physician of record for the above-referenced student and hereby confirm that this student is able to self-administer auto-injectable epinephrine, Diabetes Medications, Other Medication without the assistance of school personnel. The specific name of the medication, the method, amount and time schedules by which the medication is to be taken are set forth below.**

**Medication:**

**_____**

**Dose: _____**

**Method: _____**

**Frequency:_____**

**Possible Side Effects:**

**_____**

**I certify that the above named student has been instructed in the use and self-administration of this medication. She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. She is capable of using this medication independently.**

**Physician's Printed Name: _____**

**Phone: _____**

**Signature of Physician: _____**

**Date: _____**