NEWS FROM THE HEALTH ROOM

Now that this school year 2018/19 is coming to a close, this is a reminder to all parents who have medication here for your child. Please pick up your child's medication from the nurse's office the week of May 20th through May 31st. Rescue inhalers, Epi-pen and Benadryl may go home with the student. If they are self- carry only. If not self- carry for the rescue inhaler, Epi-pens, Benadryl meds and any other meds that are in the nurse's office have to be picked up by a parent. If a parent cannot pick up the meds, please make arrangements with an adult to pick up the med's and let the nurse know who is coming in to get them.

Starting the next school year 2019/20 if your child will need medication left at school in the nurse's office or if your child will be carrying their Epi Pens, Inhalers or Benadryl on them, they will need new forms signed and dated from both the doctor and parent. You can get the forms off the Oswego School District web site under the health section under forms. Pick up the forms in the nurse's office. Or print the forms out which are attached to this e-mail.

If your child will be keeping any Benadryl, Epi Pens or inhaler's in the nurse's office you will need to get an Allergy or Asthma Action Plan from the doctor. If your child will be carrying Epi Pens or Inhalers on themselves there will be NO need for an Action Plan. If you are keeping pain meds in the nurse's office you will need a form signed and dated from both the doctor and parent.

Remember students are not allowed to transport medications to and from school unless they are self - carry Inhalers, Epi Pens or Benadryl.

If you have any questions please contact Kathy Struve RN Thompson Jr. High building nurse at 630-636-2602.

Thank You Kathy Struve RN

Kathy Struve RN Building Nurse Thompson Jr. High

Phone Number 630-636-2602

Fax Number 630-636-2697

World-Class Schools Serving Caring Communities

Oswego Community Unit School District No. 308

School Medication Authorization Form

Student's Name _____ Birth Date _____

Address _____ Home Phone _____

School _____ Grade _____ Teacher _____

Emergency Phone Number _____

To be completed by the student's physician or parent/guardian:

Name of Medication _____
(Must be in original container)
Dosage _____ Time _____

Type of Illness or Disease _____

Is it mandatory that this medication be administered during the school day in order to allow the child to attend school?_____

Side effects to be alerted to _____

_____
Doctor's signature Date

_____ _____
Address Phone

Further Instruction Remarks _____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Oswego School District and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self-administer, which 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. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against the School District, its employees and agents, arising out of the administration of said medication. IN addition, agree to hold harmless and indemnify the School District, its employees an agents, either jointly or severally, from and against an and all claims, damages, causes of auction or injuries incurred or resulting from the administration or attempts at administration of said medicine.

_____ _____
Parent Signature Date

RETURN TO THOMPSON HEALTH OFFICE: ATTN: KATHY STRUVE
OR FAX TO: 630.636.2697

SD308
COMMUNITY UNIT
SCHOOL DISTRICT

Self Administration Form

Parent Request for Self – Administration of _____ Medication

Student's Name_____ Birth Date _____

Address _____ Home Phone_____

School _____Grade _____Teacher_____

Emergency Phone No. _____

To be completed by the student's parent/guardian:

Name of Medication_____
(Must be in original container with an individual prescription label)
Dosage _____

Type of Illness or Disease _____

I hereby authorize Community Unit School District No. 308 and its employees and agents, in my behalf and stead, 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. The student may self administer _____ Medication under the following circumstances: while at school, while at a school sponsored activity and before or after normal school activities such as while the student is in before school or after school care on school operated property.

The School District and its employees and agents will not be held liable, except for willful and wanton conduct for any injury resulting from the student's self administration of medication. I accept and waive liability any claims that I might have against the School District, its employees and agents, except a claim based on willful and wanton conduct, arising out of the student's self-administration of medication. I also understand this permission is effective for only the school year in which it has been granted, and must be renewed every subsequent school year.

_____

Parent Signature Date

Both Sides Must Be Completed

RETURN TO THOMPSON HEALTH OFFICE: ATTN: KATHY STRUVE
OR FAX TO: 630.636.2697

Community Unit School District No. 308
Physician Request for Self-Administration of _____ Medication

Name of Student _____ Birthdate _____

City _____ Zip _____ Telephone Number _____

The above named pupil has _____
(Name of Disease or Syndrome)

I am requesting that the above named student may self-administer Asthma Medication under the following circumstances: while in school, while at a school-sponsored activity under the supervision of school personnel or before or after normal school activities such as while the student is in before school or after school care on school operated property.

Name of Medication _____

Dosage _____ Time(s) to be given _____

Possible Side Effects _____

I certify that _____ has been instructed in the use and self-
(Name of Student)
Administration of _____
(Name of Medication)

He/she understands the need for the medication, and the necessity to report to school personnel and unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone number in the event of a reaction to the medication or in any emergency:

Phone number of Physician _____ Signature of Physician _____ Date _____

Address of Physician _____ Print name of Physician _____

Both Sides Must Be Completed

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OR FAX TO: 630.636.2697