



## **Individual Health Care Plan-Epilepsy**

Student:	Student's weig	jht: Date:	_
Teacher:	Grade:	School:	
Home phone:			
Medical Diagnosis & Brief Medical	al History:		
Medications/Dose:			
If you should see this:		Oo this:	
Physical Education Adaptation	าร:		
Transportation Adaptations: _			
Food Service Adaptations:			
			_
<b>Emergency Contacts (Pleas</b>	e provide an Englis	sh speaking adult):	
Parent/Guardian:	Home phone:	Cell phone:	Work:
Name/Relationship:	Home phone:	Cell phone:	Work:
Name/Relationship:	Home phone:	Cell phone:	Work:
Parent/Guardian signature		Date	



## **BOARD OF EDUCATION**

9440 North Kenton Avenue Skokie, Illinois 60076-1338 Telephone: 847/676-9000 Fax: 847/676-9232

Internet: www.Skokie68.org

## $\frac{\textbf{ADMINISTRATION OF EPILEPSY MEDICATION AUTHORIZATION, HOLD-HARMLESS}}{\textbf{AND INDEMNITY FORM}}$

Student's name:	
Date of birth:	
Home Telephone Number	
Emergency Telephone Number	
This Section must be completed and signed by either: (i) the stude assistant; or (iii) advanced practice registered nurse:	nt's physician; (ii) physician
Licensed Prescriber's Name:	
Address:	
Regular Telephone Number:	
Emergency Telephone Number:	
Name of medication:	
Dosage:	
Time and Circumstances of administration at school:	
Side effects from medication for which student must be observed:	
_	
Signature of physician, physician's assistant or advanced practice registered nurse	Date

## This Section must be completed by the student's parent or guardian:

I hereby authorize school district personnel to administer the above referenced medication to my child at school, school-sponsored activities, while under the supervision of school personnel, and before/after normal school activities such as before/after school care on school operated property.

I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees and volunteers from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnitees and arising out of a claim related directly or indirectly to the administration or attempted administration of the above referenced medication of and brought by me or any other parent or guardian of my student. We understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the administration of medication or attempted administration of medication, or any injury arising during the course of the administration of the medication provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.

Signature of Parent/Guardian	Date		
Signature of Parent/Guardian	Date		
This form shall be effective for the 20 20_ subsequent school year.	school year only, and must be renewed each		