Medication Authorization Form

THIS FORM ONLY NEEDS TO BE FILLED OUT IF YOUR CHILD WILL BE TAKING MEDICATIONS OR USING INHALERS DURING THE SCHOOL DAY. THIS INCLUDES ANY/ALL OVER THE COUNTER MEDICATIONS.

In order to be compliant with the Illinois State Board of Education guidelines, a doctor's order must be obtained for a prescription and/or over the counter medication to be given in school. This is done by having the "School Medication Authorization Form" completed and signed by your child's doctor. Please refer to the Student Handbook for further information. Thank you for your cooperation.

TO BE COMPLETED BY THE CHILD'S PARENT(S)/GUARDIAN(S). A NEW FORM MUST BE COMPLETED EVERY SCHOOL YEAR. KEEP IN THE SCHOOL ADMINISTRATION OFFICE.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School Name: _____ Grade: _____ Teacher: _____

TO BE COMPLETED BY STUDENT'S PHYSICAN ASSISTANT, OR ADVANCED PRACTICE RN:

Physician's Printed Name: _____

Office Name: _____ Emergency Phone: _____

Medication Name: _____

Diagnosis required medication: _____

Purpose: _____

Is it necessary for this medication to be administered during the school day? *(Please Circle)* Yes or No

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances:

_____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Expected side effects, if any: _____

Other medications student is receiving: _____

_____ _____

Physicians Signature **Date**

For Only Parents/Guardians of Students who need to carry asthma medication or an EpiPen®

I authorize the School District and its employees and agents, to allow my child or ward to possess and use asthma medication and/or epinephrine auto-injector: (1) while in school, (2) at a school-sponsored activity, (3) under the supervision of school personnel, or (4) before or after normal school activities. 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 or epinephrine auto-injector (105 ILCS 5/22-30) **If you agree please initial:** _____

For All Parents/Guardians

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, 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 I agree 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 administration or the child's self administration of medication.

_____ _____

Parent/Legal Guardian Signature **Date**