School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name:_____Birth Date:_____
Address:_____Home Phone:_____Emergency Phone:_____
School:_____Grade:_____Teacher:_____

*To be completed by the student's physician, physician assistant, or advanced practice RN (***Note**: *for asthma inhalers only, use the "Asthma Inhalers" section below):*

Physician's Printed Name: _____ Office Phone:_____
Office Address:_____ Emergency Phone:_____
Medication name: _____Purpose:_____
Dosage:_____ Frequency:_____
Time medication is to be administered or under what circumstances:_____
Prescription date:_____ Order date:_____Discontinuation date:_____
Diagnosis requiring medication:_____
Expected side effects, if any:_____
Is it necessary for this medication to be administered during the school day? Yes ☐ No ☐
Time interval for re-evaluation:_____
Other medications student is receiving: _____
Physician's signature_____Date_____

Asthma Inhalers : *Parent(s)/Guardian(s) please attach prescription label here:*

For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:
I authorize the School District and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. 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:***_____
Parent/Guardian

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* pursuant to State law, 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/Guardian printed name _____
Address (if different from Student's above):_____
Phone:_____ Emergency Phone:_____

Parent/Guardian signature_____ Date_____