

Student 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):

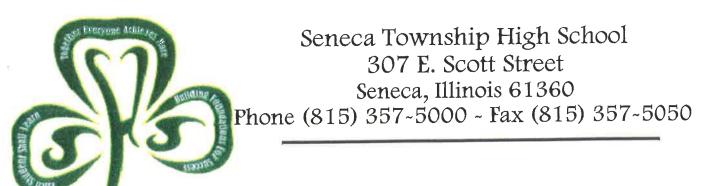
Physician's Printed Nam	e:			
Office Address:				
Office Phone:	e Phone: Emergency Phone:			
Medication name:				
Purpose:				
Dosage:	Frequency:			
Time medication is to be				
Prescription date:	Order date:	Discontinuation date:		
Diagnosis requiring med	ication:			
Is it necessary for this medication to be administered during the school day?				🗌 No
Expected side effects, if	any:			
Time interval for re-eval	uation:			
Other medications studen	nt 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).

Please initial below to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian initials

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