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's main 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:

Physician's printed name:_____

Office Address:_____

Office Phone:_____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:_____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Expected side effects, if any:_____

Time interval for re-evaluation:_____

Other medications student is receiving:_____

_____

Physician's signature Date

(Parents must complete back of form)

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 is or her asthma medication and/or 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(s)/guardians(s)

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/Guardian printed name	Parent/Guardian printed name
_____	_____
Parent/Guardian signature* Date	Parent/Guardian signature* Date

** Both parents and/or guardians, if available, should sign.*