Stark County #100 SCHOOL MEDICATION AUTHORIZATION FORM

(Prescription and Non-prescription. Must be completed by the physician for medication to be given at school)

Student_____ Birth date_____ School Year_____ Grade____ Teacher_____

TO BE COMPLETED BY THE PHYSICIAN;

Date of order_____ Name of Medication_____

Dosage/Frequency_____

Time medication is to be administered or under what circumstances_____

Diagnosis requiring medication_____

Intended Effect of Medication_____ Expected side Effect of medication_____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? YES NO

_____ _____

Physician's Name Printed Physician's telephone number

_____ _____

Physician's Signature Address

TO BE COMPLETED BY A PARENT /GUARDIAN

Prescription Medication **MUST** be brought to school in an original container appropriately labeled by the pharmacy or physician. Non-prescription medications ordered by the physician **MUST** be brought to school with the original label and the student's name affixed to the container. It is the parent's responsibility to get the required Dr. signature for the medication form.. Medication will not be given without this form completed and signed by the physician and the parent has completed the parent's part of the form. Only those medications that are necessary to maintain the student in school or must be given during the school hours shall be administered. Parents/guardian need to bring prescribed medication to the school office. Please contact the school principal or nurse with questions.

By signing below, I agree:

1. 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 on 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 an employee or agent of the School District, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices.
2. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I wave any claims that I have might against the School District, its employees and agents arising out of administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of administration of said medication, 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 Signature/Date

FOR PARENT/GUARDIAN OF STUDENTS WHO HAVE ASTHMA OR ARE AT RISK OF ANAPHYLAXIS:

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/her epinephrine auto-injector: 1) while in school, 2) while at school sponsored activities, 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 School Districts to inform parents/guardians that it and its employees and agents incur no liability, except for willful or wanton conduct, as a result of any injury arising from student's self-administration of medication or epinephrine auto-injector (105ILCS 5/22-30). By signing below, 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 self-administration of medication by the pupil.

Please check as applies: ___ asthma inhaler ____ epinephrine auto-injector

Signature of Parent/Guardian_____ Date_____

Medication Record

Student_____ Birth Date_____ School Year_____ Grade_____

Medication_____Dosage_____

Time(s) _____

	August	September	October	November	December	January	February	March	April	May
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Please Initial above and Provide time when assisting student with medication, and sign below.

_____ _____ _____SS

Signature Signature Signature

- Use Extreme care giving medication. Check information on the reverse side of this form and verify administration of the correct medication to the above student
- If medications are not given, state the reason, such as absent, etc.