MEDICATION AUTHORIZATION FORM

To be completed by the student's parent/guardian. A new form must be completed every year. Keep in the school nurse'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 R.N.

Physician's Printed Name_____

Office Address_____ Phone_____

Name of Medication_____

Intended Purpose_____

Diagnosis Requiring Medication_____

Expected Side Effects_____

Is it necessary for this medication to be administered during the school day?____Y___N

Prescription Date_____ Physician's signature_____

Fill out bottom portion only for students who need to carry asthma medication or an Epi-Pen

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his/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 parents/guardians 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 asthma medication or epinephrine auto-injector (105ILCS 5/22-30). *If you agree, please initial*_____

Student carries own inhaler_____ Student carries Epi-pen_____
Student has inhaler in office_____ Student has Epi-pen in office_____

(over)

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.