Students

Exhibit-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 assistant, or advanced practice RN (**Note**: for asthma inhalers only, use the **Asthma Inhalers** section below):*

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 medication student is receiving: _____

_____
Physician's signature Date

Asthma Inhalers

Parent(s) Guardian(s) please attach prescription here:

For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine auto-injector:

I authorize the School District and its employees and agents, to allow my child or ward to self-carry and self-administer his 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 or 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 it's employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30).

Please initial 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

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

DATED: