

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, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority (Note: for asthma inhalers only, use the Asthma Inhalers section below):

Prescriber’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: _____

Prescriber’s signature

Date

Asthma Inhalers

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

For only parents/guardians of students who need to carry and use their asthma medication or an EpiPen®:

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 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-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30).

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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(s)/guardian(s) 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, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 98-795). **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

Address (if different from Student’s above): _____

Phone: _____

Emergency Phone: _____

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

Adopted 09-16-97
Revised 12-17-01
Revised 01-16-07
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Revised 06-15-15
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