

**DUNLAP COMMUNITY UNIT SCHOOL DISTRICT #323**

**School Medication Authorization Form**

Revised 8/10/15

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.

Parent/Guardian must bring all prescription and non-prescription medications to school in the manufacturer's original container with the label indicating the ingredients and the student's name affixed.

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**FOR PRESCRIPTION MEDICATION:**

To be completed by the student's physician, 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: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time medication is to be administered / 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

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

**FOR NON-PRESCRIPTION MEDICATION:**

Medication name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time medication is to be administered / under what circumstances:

\_\_\_\_\_

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: \_\_\_\_\_

**BOTH SIDES OF FORM MUST BE SIGNED**

**DUNLAP COMMUNITY UNIT SCHOOL DISTRICT #323**

**School Medication Authorization Form**

Revised 8/10/15

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

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 or her 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/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

At the end of the treatment regime, remove any unused medication from the school. If the parent/guardian does not pick up the medication by the end of the school year, the medication will be discarded by designated staff.

**BOTH SIDES OF FORM MUST BE SIGNED**