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Cary Grove High School: 847-639-3825 / fax 847-639-3873
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Prairie Ridge High School: 815-479-0404 / fax 815-459-8993

SCHOOL MEDICATION ADMINISTRATION (SMA) FORM

This form is to be used for all medication other than medical cannabis. A new form must be completed every school year.

Date_____

Student Name_____ Date of Birth_____

School _____ Grade _____

PHYSICIAN AUTHORIZATION FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority.

Medication_____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Is the student authorized to self-administer the medication? ☐ Yes ☐ No

Dosage/Frequency_____ Route_____ Time_____

☐Scheduled ☐PRN

Effective dates (limited to 1 school year) From:_____ To:_____

Intended effect_____ Possible side effects_____

Special Instructions_____

Condition(s)/diagnosis requiring medication_____

Other medication(s) student is taking _____

Physician's Printed Name _____

Physician's Signature_____ **Date**_____

Phone_____ **Emergency Phone**_____ **Fax**_____

Address_____

FOR ASTHMA MEDICATION AND/OR EPINEPHRINE INJECTOR ONLY

***To Be Completed by Physician*:**

Is self-carry of asthma medication authorized? Yes □ No □
Is unsupervised self-administration of asthma medication authorized? Yes □ No □

Is self-carry of epinephrine injector authorized? Yes □ No □
Is unsupervised self-administration of epinephrine injector authorized? Yes □ No □

I or a member of my staff has instructed the above student in the proper self-carry and self-administration, if authorized, of the above-identified medication(s). The student understands the need for the medication, the appropriate response, and the necessity to report to school personnel any unusual side

effects or lack of appropriate response. The student is capable of using this medication independently.

Physician's Signature_____ Date_____
Physician's Name_____Phone_____ Fax_____

To Be Completed by Parent/Guardian *(initial all that apply)*:

Is the asthma medication and/or epinephrine injector required under a qualifying plan, such as: (1) an asthma action plan, (2) an Individual Health Care Action Plan, (3) an Ill. Food Allergy Emergency Action Plan and Treatment Authorization Form, (4) a plan pursuant to Section 504 of the federal *Rehabilitation Act of 1973*, or (5) a plan pursuant to the federal *Individuals with Disabilities Act*? Yes □ No □

I consent only to my child's self-carry of asthma medication: _____
I consent to my child's self-carry and unsupervised self-administration of asthma medication : _____

I consent only to my child's self-carry of an epinephrine injector: _____
I consent to my child's self-carry and unsupervised self-administration of an epinephrine injector: _____

I hereby acknowledge that the District, and its employees and agents, incurs no liability, except for willful and wanton conduct, as a result of any injury arising from my child's self-carry and self-administration of asthma medication and/or epinephrine 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: _____

For asthma inhalers, attach the prescription label with the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered. 105 ILCS 5/22-30(b)(2)(i).

For an epinephrine injector, attach a written statement from the student's physician, physician assistant, or advanced practice registered nurse containing the name and purpose of the epinephrine injector; the prescribed dosage; and the time or times at which or the special circumstances that the epinephrine injector should be administered. 105 ILCS 5/22-30(b)(2)(ii)(A)-(C).

FOR SELF-ADMINISTRATION OF MEDICATION OTHER THAN ASTHMA MEDICATION AND/OR EPINEPHRINE INJECTOR ONLY

To be completed by parents/guardians of students who need to self-administer medication (other than an asthma inhaler and/or epinephrine injector) required under a qualifying plan. Please initial.

I consent to my child's self-administration of his/her medication (other than an asthma inhaler and/or epinephrine injector) required under an asthma action plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization Form, a plan pursuant to Section 504 of the federal *Rehabilitation Act of 1973*, or a plan pursuant to the federal *Individuals with Disabilities Education Act*: _____

PARENT/GUARDIAN AUTHORIZATION

I hereby acknowledge 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 Community High School District 155 and it employees and agents, on my behalf and stead, to administer or attempt to administer to my child, or allow my child to self-administer, the lawfully prescribed medication in the manner described in this authorization form.

I further understand my child may be administered an undesignated epinephrine injectors, opioid antagonists, or asthma medication to my child when school personnel have a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on-site or has expired.

I acknowledge that it may be necessary for the administration of medication(s) to my child to be performed by an individual other than the school nurse, and specifically consent to such practices.

I waive any claims I might have against the School District, the Board of Education and its members, its employees, and its agents arising out of the administration or my child's self-administration of said medication(s). In addition, I agree to hold harmless and indemnify the School District, the Board of Education and its members, its employees, and its agents, either jointly or severally, from any and all claims, demands, damages, and causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the negligent administration or self-administration of medication(s).

Parent/Guardian Signature_____ **Date**_____

For School Use: PRN Medication Administration									Medication Intake:____/____/____ Amount:_____				
Date													
Time													
Initial													
Date													
Time													
Initial													
Signature_____Initial_____				Signature_____Initial_____					Signature_____Initial_____				

SCHOOL MEDICATION AUTHORIZATION AND ADMINISTRATION PROCEDURE

Whenever possible, the parent/guardian should make arrangements for medication to be administered at home, before or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, **school district policy and procedures must be followed for administering all medications, as outlined in Community High School District 155 Policy Manual (Board Policy 7:270 Administering Medicines to Students)**.

1. Medication is defined as prescription or non-prescription (over the counter) drugs.

2. Medication cannot be administered without a written physician's order and written parent/guardian permission.

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must be brought in with the original manufacturer's label, clearly marked with the student's name.

4. It is the parent/guardian's responsibility to supply prescribed medication and assure that it is brought to school by a responsible person.

5. All medications to be taken during school hours will be kept in the nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication.

6. For metered dose asthma medication and epinephrine injectors only: students may carry their asthma medication and epinephrine injectors and self-administer medication as prescribed. Asthma medication and epinephrine injectors must be properly labeled and stored in a safe accessible location.

7. **If a student is unable to self-administer asthma medication or epinephrine injector**, parent must notify the school nurse.

8. The parent/guardian must assume responsibility for informing the school (in writing) of any change in the student's health or change in medication. Physician's order must accompany any medication change.

9. The District retains the discretion to reject requests for administration of medication if all required information is not received on the authorization form.

10. Medication authorization must be renewed each school year.

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