



Cary Grove High School: 847-639-3825 / fax 847-639-3873  
 Crystal Lake Central High School: 815-459-2505 / fax 815-459-4169  
 Crystal Lake South High School: 815-455-3860 / fax 815-477-6907  
 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's 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

Dose/Frequency \_\_\_\_\_ Route \_\_\_\_\_ Time \_\_\_\_\_  Scheduled  PRN

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

Intended effect \_\_\_\_\_ Possible side effects \_\_\_\_\_

Special Instructions \_\_\_\_\_ Condition(s) requiring medication \_\_\_\_\_

Other medication(s) student is taking \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Emergency Phone \_\_\_\_\_ Fax \_\_\_\_\_

#### For Asthma Medication and/or Epinephrine Injector Only

*To be completed by physician:*

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

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

I or a member of my staff have 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 \_\_\_\_\_

**\*\*\*Parent's Authorization must be completed and signed on page 2.\*\*\***

For School Use: PRN Medication Administration										Medication Intake: ___/___/___ Amount: ___			
Date													
Time													
Initial													
Date													
Time													
Initial													
Signature _____		Initial _____		Signature _____		Initial _____		Signature _____		Initial _____			

## 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 its employees and agents, on my behalf and stead, to administer or attempt to administer, or allow my child to self-administer, the lawfully prescribed medication in the manner described in this authorization form.

I further understand that my child may be administered an undesignated epinephrine injector, opioid antagonists, or asthma medication 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 onsite 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 of self-administration of medication(s).

### For Asthma Medication and/or Epinephrine Injector ONLY

*To be completed by parent/guardian of students who need to self administer medication asthma inhaler and/or epinephrine injector. Please initial.*

Is the asthma medication an/or epinephrine injector required under a qualifying plan, such as: (1) an asthma action plan, (2) an Individual Health Care action plan, (3) an IL Food Allergy emergency action plan and treatment authorization form, (4) a plan pursuant to Section 504 *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: \_\_\_\_\_

### For Self-Administration of Medication other than Asthma Medication and/or Epinephrine Injector ONLY

*To be completed by parent/guardian of students who need to self administer medication (other than 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 IL Food Allergy emergency action plan and treatment authorization form, a plan pursuant to Section 504 *Rehabilitation Act of 1973*, or a plan pursuant to the federal *Individuals with Disabilities Act*: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Phone Number \_\_\_\_\_ Date \_\_\_\_\_

## 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).**

- Medication is defined as prescription or non-prescription (over the counter) drugs.
- Medication cannot be administered without a written physician's order and written parent/guardian permission.
- 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.
  - 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 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(s) at which or the special circumstances that the epinephrine injector should be administered. *105 ILCS 5/22-30(b)(2)(ii)(A)-(C)*
- It is the parent/guardian responsibility to supply prescribed medication and assure that it is brought to school by a responsible person.
- 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.
- 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.
- The school district retains the discretion to reject requests for administration of medication if all required information is not received on the authorization form.