WEST NORTHFIELD
SCHOOL DISTRICT NO. 31

Medication Authorization Form

In accordance with School Code of Illinois, all students administered medications at school must submit this form. This form must be signed by the physician and the parent/guardian and is valid for one year or until revoked by the physician and/or parent/guardian.

STUDENT INFORMATION

(To be completed by the **parent/guardian**)

Student Name_____ Birthdate_____ Grade_____

Address_____ Phone # _____

Parent's/Guardian's Name_____ Emergency Phone # _____

PHYSICIAN ORDER FOR ADMINISTRATION OF MEDICATION

(To be completed by **physician**)

Name of Medication: _____

Condition Prescribed For: _____

Dosage_____Route:_____

Frequency and Time of Administration:_____

Possible Side Effects: _____

Other Medications Student is receiving: _____

Necessary to take during school day to attend school / field trips (circle): YES NO

Physician Signature:_____Date:_____

Print Physician Name:_____Phone#:_____

Physician Address:_____ Fax#:_____

PARENT MUST COMPLETE PARENT AUTHORIZATION ON PAGE 2

PARENT- AUTHORIZATION WAIVER AND INDEMNIFICATION
(To be completed/signed by the parent/guardian)

I am aware that no medication, including any over-the counter medication such as "Tylenol" will be given at school or a school related function without this signed form. The prescribed medication must be brought to school by the parent/guardian in a container appropriately labeled by the pharmacy or physician. Any unused medication not picked up by the designated date at the end of the school year will be discarded.

I herewith acknowledge that I am primarily responsible for administering medications to my child. However, in the event that I am unable to do so or in the event of a medical emergency or if my child requires daily medication, I hereby authorize West Northfield School District 31 and its employees and agents, on my behalf and stead, to administer or 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 according to the above instructions. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a certified and registered school nurse and specifically consent to this. I waive any claims against the School District, the Board of Education and its members, employees, and agents arising out of the administration or my child's self-administration of said medication, and agree to hold harmless and indemnify the School District, the Board of Education and its members, employees and agents, either jointly or severally, from and against any and all liability claims, damages, or causes of actions or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the negligent administration or self-administration of medication. "Indemnify" in this document means that I agree to compensate, reimburse, or repay West Northfield School District 31 for any liability claims, damages, expenses, or losses that may arise from or arises out of the negligent administration or self-administration of medication to my child. With respect to the administration of asthma medication, or an epinephrine auto-injector (whether designated or undesignated) or an opioid antagonist regardless of whether authorization was given by me or by my child's physician, physician's assistant, or advanced practice registered nurse, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

For Asthma Medication/Epinephrine Auto-Injectors Only
(Check and initial all that apply)

__ I consent to my student's self-carry **and** unsupervised self-administration of asthma medication. ***Initials***: _____
__ I consent to **only** to my student's self-carry of asthma medication. ***Initials***: _____
__ I consent to my student's self-carry **and** unsupervised self-administration of an epinephrine auto-injector. ***Initials***:___
__ I consent **only** to my student's self-carry of an epinephrine auto-injector. ***Initials***: _____

I further understand my child may be administered an undesignated epinephrine auto-injector or opioid antagonist when school personnel have a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reaction is known to me or not.

Parent Signature:_____Date:_____

Parent # (Home):_____Parent # (Cell):_____