

Sandridge School

2950 Glenwood-Dyer Road
Chicago Heights, IL 60411

(708) 895-2450
Fax: (708) 895-2451



SCHOOL MEDICATION AUTHORIZATION FORM

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

*To be completed by the student's PHYSICIAN, PHYSICIAN ASSISTANT, or ADVANCED PRACTICE RN
(PLEASE NOTE: all areas with an asterisk (*) are required to complete)*

* Physician's Printed Name: _____

* Office Address: _____

* Office Phone: _____ * Secondary Phone: _____

* Medication Name: _____

* Purpose: _____

* Dosage: _____ * Frequency: _____

* Time medication is to be administered or under what circumstances: _____

* Prescription Date: _____ * Order Date: _____ * Discontinue 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

PARENT/GUARDIAN'S CONSENT AUTHORIZING ADMINISTRATION OF MEDICATION

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, on 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. This includes administration of undesignated epinephrine auto-injectors or opioid antagonist to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **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 ADDRESS)

Phone #: _____

Emergency Phone #: _____

PARENT/GUARDIAN SIGNATURE

DATE

I further represent to the School District that my child IS IS NOT (check one) capable of self-administering the medication.

PARENT/GUARDIAN SIGNATURE

WORK OR CELL PHONE #

ATTENTION: This section is ONLY for Parents/Guardians of students who need to carry an Asthma Inhaler 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).

Please initial below to indicate receipt of this information, and please sign and date if you authorize your child to carry and use his or her asthma medication or epinephrine auto-injector.

INITIALS

PARENT/GUARDIAN SIGNATURE

DATE