



## School Medication Authorization Form

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

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

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

Complete sections 1 and 3 if your student uses an Epinephrine injector or Asthma inhaler

Complete sections 2 and 3 for all other medications that your student needs to have available at school.

Please send completed forms to the school nurse

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

### 1. Students requiring asthma medication and/or epinephrine injectors

Is the asthma inhaler and/or epinephrine injector required under a qualifying plan pursuant to 105 ILCS 5/10-22.21b, amended by P.A. 101-205? ☐ Yes ☐ No

**For asthma inhalers**, attach the prescription label below 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).\*

\*required

(Section 1 continued on page 2)



***For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:***

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her 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. Illinois law requires the School District to inform parents/guardians 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-carry and self-administration of asthma medication or epinephrine injector. 105 ILCS 5/22-30, amended by P.A 102-413.

**Please initial to indicate (1) receipt of this information, and (2) authorization for your child to carry and use his or her asthma medication or epinephrine injector.**

\_\_\_\_\_  
Parent/Guardian Initials



## 2. Over the Counter and Prescription Medications

All medications require a physician's signature and must be brought to the nurse's office in original pharmacy or store packaging. Students are not permitted to carry or self administer any medication except those prescribed for an allergic emergency, asthma or are required under a qualifying plan. One Medication per form, please submit additional forms for multiple medications.

Prescriber's Printed Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Medication Name: \_\_\_\_\_

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

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

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

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

Time medication is to be administered or under what circumstances: \_\_\_\_\_

Prescription Date: \_\_\_\_\_ Order Date: \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_

Diagnosis requiring medication: \_\_\_\_\_

Expected Side effects, if any: \_\_\_\_\_

Time interval for re-evaluation: \_\_\_\_\_

Other medication the student is receiving: \_\_\_\_\_

Medication student permitted to self administer (qualifying plan required, see below) \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***For only parents/guardians of students who need to self-administer medication required under a qualifying plan:***

I grant permission for my child to self-administer his or her medication 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. 105 ILCS 5/10-22.21b, amended by P.A. 101-205.

**Please initial to indicate (1) receipt of this information, and (2) authorization for your child to self-administer medication under a qualifying plan.**

\_\_\_\_\_  
Parent/Guardian Initials



### 3. Parent/Guardian Authorization

***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 undesigned epinephrine injectors, opioid antagonists, or asthma medication, to the extent the School District maintains such undesigned supplies, to my child when there is 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. 105 ILCS 5/22-30, amended by P.A 102-413.; 105 ILCS 145/27, added by P.A. 101-428. **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 the student's above: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ALL STUDENTS. OUR STUDENTS.

542 Abbotsford Rd., Kenilworth IL 60043 | 847.256.5006 | kenilworth38.org