

# SPECIAL EDUCATION DISTRICT OF LAKE COUNTY

18160 W Gages Lake Road, Gages Lake, Illinois 60030-1819  
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www.sedol.us



**Valerie M. Donnan, M.Ed.**  
Superintendent

## Medication Authorization – Medical Cannabis

Medications cannot be administered at school without a doctor's written order and form completed by the child's parent(s)/guardian(s).

School: \_\_\_\_\_  
Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Parent/Guardian Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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### THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCE PRACTICE RN WITH PRESCRIPTIVE AUTHORITY:

Medication Name: \_\_\_\_\_ Purpose: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Time Interval to be taken: \_\_\_\_\_ Duration: \_\_\_\_\_  
Take under what circumstances: \_\_\_\_\_  
Prescription Date: \_\_\_\_\_ Order Date: \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_  
Diagnosis requiring medication: \_\_\_\_\_  
Is it necessary for this medication to be administered during the school day?  Yes  No  
Expected side effects, if any: \_\_\_\_\_  
Other medications student is receiving: \_\_\_\_\_  
IDPH registry ID card for student is valid [insert dates]: \_\_\_\_\_  
IDPH registry ID card for designated caregiver is valid [insert dates]: \_\_\_\_\_

### Attach copies of both registry identification cards

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Prescriber's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_ FAX: \_\_\_\_\_  
PLEASE PRINT

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### TO THE PARENT/GUARDIAN:

#### SELF-ADMINISTRATION ONLY - UNDER DIRECT SUPERVISION

I grant permission for my child to self-administer his or her medical cannabis infused product required under an asthma action plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization From, 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, eff. 1-1-20. I understand that my child's self-administration will only occur under direct supervision by a school nurse or school administrator. 105 ILCS 5/22-33(b-5), amended by P.A. 101-370, eff. 1-1-20.

Medical cannabis infused product child is permitted to self-administer:

**Please initial to indicate (1) receipt of this information, and (2) authorization for your child to self-administer a medical cannabis infused product.**

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

All medications to be taken at school must be supplied by the parent/guardian per SEDOL policy. This request terminates at the end of the prescribing physician's orders or the end of the current school year, whichever occurs first. SEDOL Nursing may consult with the prescribing physician regarding school medication.

By signing below, I acknowledge, understand and agree as follows:

1. The only individual(s) who may possess and administer medical cannabis to my child at school or on the bus is:
  - a. His/her registered designated caregiver as identified by the Illinois Department of Public Health
  - b. A school nurse or school administrator
2. Both my child and his/her registered designated caregiver possess valid registry identification cards issued by the Illinois Department of Public Health, copies of which I have provided to the District.
3. After administering the medical cannabis to my child, the designated caregiver shall immediately remove the product from school premises or the school bus.
4. The designated caregiver may not administer a medical cannabis infused product in a manner that, in the opinion of the District or school, would create a disruption to the school's educational environment or would cause exposure of the product to other students.
5. Children under age 18 cannot smoke or vape medical cannabis. Medical cannabis-infused products include oils, ointments, foods, and other products that contain usable cannabis but are not smoke or vaped.
6. The District reserves the right to restrict or otherwise stop allowing the administration of medical cannabis to my child if the District or school would lose federal building funding as a result.
7. 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 of medical cannabis that I authorize by my signature below.

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**Parent/Guardian Signature** **Date**

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**Parent/Guardian Printed Name**

cc: SEDOL Nurse  
Central File  
Student ID# \_\_\_\_\_