Student Medication Authorization Form

Student's ID #_____

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

To be completed by the student's physician, physician assistant, or advanced practice RN

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication Name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or 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: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____

Physician's Signature Date

Asthma Inhalers
Parent(s)/Guardian(s) please attach prescription label here:

For only parents/guardians of students who need to carry asthma medication or an EpiPen:
I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication and/or 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). If you agree please sign:

_____
Parent(s)/guardian(s) Signature

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, in 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. 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		Parent/Guardian printed name	
Parent/Guardian signature*	Date	Parent/Guardian signature*	Date

Address: If different from Student's above: _____

Phone: _____ Emergency phone: _____

*Both parents and/or guardians, if available, should sign.

Nurse's Office FAX Numbers: Sandburg: 708-737-7721 Stagg: 708-737-7717 Andrew: 708-737-7725