Students

Exhibit - Medication Authorization Form

To be completed by the child's parent(s)/guardian(s).

This form is to be used for medication other than medical cannabis. (See 7:270-E2, School Medication Authorization Form - Medical Cannabis.) A new form must be completed every school year for each medication. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Niles North High School, Health Center
9800 N. Lawler Avenue
Skokie, Illinois 60077
847-626-2275 / Fax 847-626-3375

Niles West High School, Health Center
5701 W. Oakton Avenue
Skokie, Illinois 60077
847-626-2940 / Fax 847-626-3520

Student Name: ____________ Date of Birth: ____________ ID #: ____________

Address: ____________

Home Phone: ____________ Cell Phone: ____________ Emergency Phone: ____________

School: ____________ Grade: ____________ Teacher: ____________

NON-PRESCRIPTION MEDICATIONS – This authorization form is valid until graduation unless otherwise specified. Non-prescription medication MUST be in the manufacturer's labeled container.

Medication: ____________ Dosage: ____________

Time Given/Frequency: ____________ Route: ____________

Reason for medication and/or intended effect: ____________

PRESCRIPTION MEDICATIONS – This form must be completed annually for ALL prescription medications. Prescription medication MUST be in containers labeled by a pharmacist.

Medication: ____________ Dosage: ____________

Time Given/Frequency: ____________ Route: ____________

Prescription Medication Start Date: ____________ End Date: ____________

Reason for medication and/or intended effect: ____________

Possible side effects: ____________

Special Instructions: ____________

Other medications student is receiving: ____________

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

Rescue inhaler and/or Epipen - We recommend "back up" medication be stored in Nurses' Office.

1. Student may carry medication on his/her person ☐ Yes ☐ No

2. Student may self-administer medication. ☐ Yes ☐ No

Directions for self-administration: ____________________

Physician's Name (Print): ____________________ Office Stamp/Address

Physician's Signature: ____________________

Date: __________ Phone(s): ____________________

ASTHMA INHALERS AND/OR EPINEPHRINE INJECTORS

For only Parent(s)/Guardian(s) of students requiring asthma inhalers 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

Parents/Guardians please attach prescription label (asthma inhaler) and/or written statement (epinephrine injector) here:

For asthma inhalers, attach the prescription label 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).

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 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-carry and self-administration of asthma medication or epinephrine injector. 105 ILCS 5/22-30, amended by P.A.s 100-726 and 100-799.

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.

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Parent/Guardian Initials

SELF-ADMINISTER MEDICATION

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, eff. 1-1-20.

Medication(s) other than asthma inhalers and/or epinephrine injectors (complete section above) required under a qualifying plan that student is permitted to self-administer:

____

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: ______________________________________

______________________________ ____________

Prescriber's Signature Date

If the medication is an asthma inhaler or epinephrine injector, be also sure to complete the section above and attach the required label and/or written statement as required above.

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

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Parent/Guardian Initials

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.

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Parent/Guardian Initials

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 Niles Township High School District 219 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 injectors, opioid antagonists, or asthma medication to the extent the School District maintains such undesignated 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, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on-site of has expired. 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.** I understand that this medication authorization is only effective for the current school year and will need to be renewed each subsequent school year.

I waive any claims I might have against the District, its employees and agents, arising out of the administration or self-administration and carry of said medication, regardless of whether the authorization for self-administration and carry of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration and carry of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed.

Parent/Guardian Printed Name ______________________________

Parent/Guardian's Signature: ______________________________

Date: ______________________________

Parent/Guardian's Emergency Phone: ______________________________

Admin. Review: October 11, 2022