THORNTON TOWNSHIP HIGH SCHOOLS DISTRICT 205
SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT NAME_____BIRTHDATE _____

ADDRESS_____PHONE NUMBER_____

SCHOOL_____GRADE _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I,_____, parent or guardian of _____ am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Thornton Township High Schools District 205 (the "District"), and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of the District, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. 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. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the District, its employees and agents, arising out of the administration or self-administration of said medication, 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 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 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.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

II. TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER
(Except for a Student Self-Administering Asthma Medication, see Section III below)

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Epinephrine: _____Yes _____No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of Epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of doing this independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: _____Yes _____No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____	_____	
Phone Number of Physician	Signature of Physician	Date
_____	_____	
Address of Physician	Print Name of Physician	Date

III. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: _____Yes _____No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____