MEDICAL

Order/Authorization for Administration of Medication at School

This form shall be effective for the 20____ – 20____ School Year ONLY and MUST be renewed each school year

TO BE COMPLETED BY THE STUDENT'S PARENT(S)/GUARDIAN(S)

Student Name: _____ Birthdate: _____

Address: _____ Home Phone: _____

Emergency Contact Name: _____ Phone: _____

School: _____ Grade: _____ Teacher: _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, PHYSICIAN ASST., OR ADVANCED PRACTICE RN

Diagnosis: _____

Medication Name (1): _____

Route of Administration: _____ Dosage: _____ Frequency: _____

Prescription Date: _____ Discontinuation Date: _____

Side Effects/Comments: _____

Medication Name (2): _____

Route of Administration: _____ Dosage: _____ Frequency: _____

Prescription Date: _____ Discontinuation Date: _____

Side Effects/Comments: _____

Other Medication student is receiving: _____

Physician's Printed Name or Office Stamp: _____ Phone: _____

Office Address: _____

Physician's Signature: _____ Date: _____

ASTHMA INHALERS ONLY – PLEASE ATTACH PRESCRIPTION LABEL BELOW:

Please see other side

This section ONLY for parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector

I authorize Lincolnwood School District 74 and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her 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 Lincolnwood School District 74 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: _____ Date: _____
Parent/Guardian

This section must be completed by the STUDENT

For students with asthma - I agree: (1) To safely store my inhaler; (2) To never share the inhaler with another person; and (3) To notify a teacher or other responsible adult if there is not a marked improvement in my breathing after two puffs of the inhaler.

For student with severe allergies - I agree: (1) To safely store my Epipen; (2) To not trade food with others; (3) To not eat anything with unknown ingredients or known to contain any allergens; and (4) To notify a teacher or other responsible adult immediately if I eat something I believe may contain a food I am allergic to.

Student Signature: _____ Date: _____

This section must be completed by 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 Lincolnwood School District 74 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 Lincolnwood School District 74), 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 Lincolnwood School District 74 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 Student)

Phone: _____ Emergency Phone: _____

Parent/Guardian Signature: _____ Date: _____

Please see other side