Adlai E. Stevenson High School District 125

Medication Authorization Form

Student's Name: _____ ID #: _____ Date of Birth: _____

The School Medication Authorization Form must be completed prior to medication administration in the school setting for prescription and/or over-the-counter medications, except that a separate authorization form is required for medical cannabis.

Health Services keeps these over-the-counter medications in stock: Ibuprofen (Advil), Acetaminophen (Tylenol), and Diphenhydramine (Benadryl). All other non-prescription medications must be brought to the Health Office by a parent/guardian in a manufacturer-labeled container. Authorization for over-the-counter medication(s) by the parent/guardian and health care provider is valid until the student's graduation unless revoked in writing or otherwise specified below.

To be completed by the student's physician, physician assistant, or APRN with prescriptive authority:

Over-The-Counter Medication

I hereby authorize the Adlai E. Stevenson High School District 125 to administer the following medication(s) during school hours:

- ☐ **Ibuprofen/ Advil/ Motrin every 6 hours as needed (Dosage: _____)**
- ☐ **Acetaminophen/ Tylenol every 4 hours as needed (Dosage: _____)**
- ☐ **Diphenhydramine/ Benadryl 1-2 tablets (25 mg each) for allergy symptoms or allergic reaction**
- ☐ **Other over-the-counter medication: _____ Dosage: _____ Frequency: _____**

Time period or other limitation for this authorization (if none, write "N/A"): _____

Prescription Medication:

Prescription medications must be brought to the Health Office by the parent/guardian with the appropriate dosage, frequency, and name clearly visible on the pharmacy labeled container. The medication authorization form must be renewed every year for prescription medications.

Medication Name: _____ Dosage: _____ Frequency: _____

Diagnosis requiring medication: _____ Purpose: _____

It is necessary for this medication to be administered during the school day and/or school-related activities: □Yes □No

Time medication is to be administered or under what circumstances: _____

Expected side effects: _____

Other prescription medications the student is receiving/taking currently: _____

Authorization for self-carry and/or self-administration of epinephrine, insulin or other medication (Not Required For Asthma Inhaler):

1) Do you authorize this student to self-carry the above medication? □**Yes** □ **No**

2) Do you authorize this student to self-administer the above medication? □ **Yes** □ **No**

By checking yes to the above, I certify that the student has been instructed in the use of the above medication, understands the need for the medication, understands the need to report any unusual side effects to school personnel, and if authorized to self-administer the medication, is capable of administering it independently under the supervision of school personnel.

Prescriber Printed Name: _____

Office Address: _____

Office Phone #: _____

Office Fax #: _____

Office Stamp

Prescriber Signature: _____ Date _____

To be completed by the Parent/Guardian:

By signing below, I, the parent/guardian of the above listed student, 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 medical emergency, I hereby authorize School District 125 and its employees and agents, on my behalf, to administer (or to allow my child to self-carry/self-administer medications pursuant to State law, while under the supervision of the employees and agents of School District 125) lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication 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 when my child's glucagon is not available on-site or has expired. 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, such as but not limited to athletic trainers during sports activities, school sponsors/chaperones during after school activities, off campus field trips, or overnight trips, and I, the parent/guardian, specifically consent to such practices. I agree to indemnify and hold harmless the School District and its employees/agents against any claims arising out of the administration of medication to my child or my child's self-administration of medication.

Parent/Guardian Printed Name:_____ **Date:** _____

Parent/Guardian Signature: _____ **Phone #:** _____

Authorization for self-carry and/or self-administration of asthma inhaler, epinephrine, insulin or other medication required under a qualifying plan:

I authorize the School District and its employees and agents, to allow my child to _____ self-carry and/or _____ self-administer **(please initial next to applicable authorizations)** his or her asthma medication, epinephrine injector, or any other medication as required under an Asthma Action Plan, a Diabetes Care Plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization Form, a Seizure Action Plan, a plan pursuant to Section 504 of the *Rehabilitation Act of 1973*, or a plan pursuant to the *Individuals with Disabilities Education Act*: (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, epinephrine injector or any other authorized medications.

Parent/Guardian Printed Name:_____ **Date:** _____

Parent/Guardian Signature: _____ **Phone #:** _____

POLICY:
Parents/guardians have the primary responsibility for the administration of medication to their children. The administration of medication to students during regular school hours and during school related activities is discouraged unless necessary for the critical health and well being of the student. The administration of medication to students is subject to guidelines established by the Superintendent or designee, in keeping with state agency recommendations (e.g., IDPR, IDPH & ISBE). *Board Policy 7.270.*

PROCEDURES/GUIDELINES:
Medication Authorization Form: School personnel shall not administer to any student, nor shall any student possess or consume *any prescription or non-prescription medication* except after filing complete medication authorization information. The school nurse reviews the written authorization and consults with the parent/guardian, licensed prescriber or pharmacist for additional information as necessary. Authorization and any subsequent changes includes:

A. Physician, advanced practice registered nurse, physician's assistant, dentist, or podiatrist-licensed prescriber's written prescription
B. Student's name, medication name, dosage and date of order
C. Administration instructions (route, time or intervals, duration of prescription)
D. Reason/intended effects and possible side effects
E. Parent/guardian written permission.

Appropriate Containers: Medication and refills are to be provided in containers, which are:

A. Prescription labeled by a pharmacy or licensed prescriber displaying Rx number, student name, medication, dosage, and directions for administration, date and refill schedule and pharmacist name *(Your pharmacy can usually provide an extra prescription container for school storage upon request).*
B. Manufacturer labeled, non-prescription over-the-counter medication.

Administration of Medication will be done by a Certified School Nurse, Registered Nurse, or other designated school employee/agent. It may be necessary for the administration of medications to be performed by a school employee/agent other than a school nurse during athletic activities, after-school activities, off campus field trips and overnight trips. The school nurse or administration retains the discretion to deny requests for administration of medication.

Self-Administration: A student may self-administer medication at school and activities if ordered by his/her medical provider. Parent signature on this form acknowledges that "the school district is to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the pupil and that the parents/guardians 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 self-administration of medication by the pupil." *Reference IL PA 100- 0799 & IL PA 96-1485*

Stock Medications: Acetaminophen, Ibuprofen and generic Benadryl are kept in stock at school for student medication administration, however, a completed Medication Authorization Form must be current, completed and on file with the Health Office prior to administration. A one time dose may be given with phoned parent permission in urgent situations. A Medication Authorization Form will then be sent home for completion and no further doses will be provided without the completed form on file.

Storage and Record Keeping:- Medication will be stored in a locked cabinet. Medication requiring refrigeration will be stored in a secure area. All medication administration will be recorded in the student's individual electronic health record. Medication counts will be performed and documented when prescription medication is received. In the event a dose is not administered and must be wasted, the reason shall be entered in the record and the medication count will be modified. Parents may be notified if indicated and it shall be documented in the student's health record..

Documentation, Changes, Renewals, and Other Responsibilities: To facilitate required documentation, medical orders, changes in physician orders, and parent permissions may be faxed, emailed, or brought in person to either Health Office. It is the responsibility of the parent/guardian to be sure that all medication orders and permissions are brought to school, refills provided when needed, and to inform the nurse of any significant changes in the student's health. Medications remaining at the end of the school year should be picked up by a parent/guardian. If the medication is not picked up by the parent/guardian at the end of the school year, it will be discarded. Every prescription medication order must be renewed each school year. Over-the-counter medication orders will be honored for the duration of the student's enrollment at School District 125, unless otherwise specified by the physician.

SHS Health Office Contact Information: Email: health_forms@d125.org Fax: 847-955-2445 Phone: 847-415-4022