

**SPECIAL EDUCATION DISTRICT OF LAKE COUNTY**

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**Dr. Judy Hackett, EdD**  
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Co-Interim Superintendents

**MEDICATION & TREATMENT AUTHORIZATION FORM**

Medications cannot be administered at school without a doctor's written order and a written request from the parent or guardian.

School: \_\_\_\_\_

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PHYSICIAN:**

**Medication/Treatment (1):** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time interval to be taken: \_\_\_\_\_ Duration: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Condition for which medication is being given: \_\_\_\_\_

Must this medication be administered during the school day in order to allow child to attend school or to address the child's medical condition?  Yes  No

**Medication/Treatment (2):** \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time interval to be taken: \_\_\_\_\_ Duration: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Condition for which medication is being given: \_\_\_\_\_

Must this medication be administered during the school day in order to allow child to attend school or to address the child's medical condition?  Yes  No

**Physician's Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ Office Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

PLEASE PRINT

**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 SEDOL 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 SEDOL), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication, to the extent SEDOL 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 or has expired, if applicable, use of undesignated oxygen. 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,** and

I agree to indemnify and hold harmless SEDOL 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's above): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

**Parent/Guardian Signature**

**Date**

I hereby request and grant permission for professional school personnel to administer the above prescribed medication(s) to my child during the school day.

**Parent/Guardian Signature**

**Date**

**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.

**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.*

\_\_\_\_\_  
Parent/Guardian Initials

**For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:**

I authorize SEDOL 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 SEDOL 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.***

\_\_\_\_\_  
Parent/Guardian Initials

cc: SEDOL Nurse  
Central File  
Student ID# \_\_\_\_\_