

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form is valid for the current school year _____ (including the summer session if applicable).

- + This form must be completed annually and signed by the licensed healthcare professional and the Parent/Guardian in order for the school to administer medication to any student or for a student to self-carry/self-administer emergency medication.
- + Any medication brought to school must be in a container appropriately labeled by the pharmacy or the manufacturer's original container (for non-prescription medications).
- + All medication must be delivered to and picked up from the school by the Parent/Guardian or other responsible adult by the last day of school.

STUDENT NAME: _____ DOB: _____ GRADE: _____
SCHOOL: _____ Phone# _____ Fax# _____

LICENSED HEALTHCARE PROFESSIONAL AUTHORIZATION

Medication Name: _____ Dosage: _____ Route: _____
Frequency/Time: _____ Indication: _____ Discontinuation Date (if applicable): _____
Expected Side Effects: _____

Medication Name: _____ Dosage: _____ Route: _____
Frequency/Time: _____ Indication: _____ Discontinuation Date (if applicable): _____
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Medication Name: _____ Dosage: _____ Route: _____
Frequency/Time: _____ Indication: _____ Discontinuation Date (if applicable): _____
Expected Side Effects: _____

I have examined the student and have determined that the medication(s) are necessary for the student to take during the school day in order to attend school.

Licensed Healthcare Professional Signature

Date

Printed Name: _____

Address: _____

Phone #: _____

**LICENSED HEALTHCARE PROFESSIONAL AUTHORIZATION FOR STUDENT TO SELF-ADMINISTER AND/OR
SELF-CARRY EMERGENCY MEDICATION (if applicable)**

(Asthma medication, Epinephrine injector, Diabetic management medication, or Seizure emergency medication)

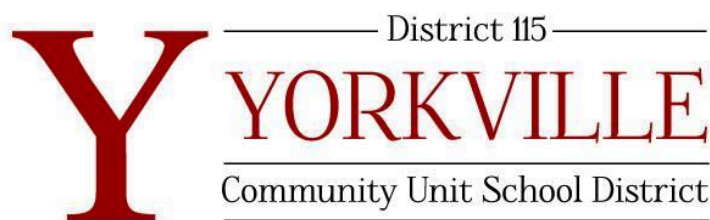
I certify that the identified student has been instructed in the use and self-administration of their medication. They understand the need for the medication and the necessity to report to school personnel any unusual side effects. The student is capable of using this medication independently.

☐ Student may self-carry

☐ Student may self-administer

Licensed Healthcare Professional Signature

Date



Administrative Center · 800 Game Farm Road · Yorkville, Illinois 60560 · 630-553-4382 · y115.org

PARENT/GUARDIAN AUTHORIZATION

I hereby acknowledge 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 authorize Yorkville Community Unit School District 115 and its employees and agents, on my behalf, to administer or to attempt to administer to my child, or allow my child to self-administer, the lawfully prescribed medication in the manner described in this authorization form. I acknowledge that it may be necessary for the medication to be administered to my child by an individual other than a school nurse, and I specifically consent to such practices. Additionally, I waive any claims I might have against District 115, the Board of Education and its members, its employees, and its agents arising out of the administration or attempt to administer to my child or my child's self-administration of the medication(s). I also agree to hold harmless and indemnify District 115, the Board of Education and its members, its employees, and its agents from and against any and all claims, demands, damages, causes of action, injuries, costs, and/or expenses, including attorney's fees, resulting from or arising out of the administration or attempt to administer to my child or my child's self-administration of the medication(s).

Additionally, I authorize Yorkville Community Unit School District 115 and its employees and agents to communicate with my child's prescribing healthcare professional regarding my child's medication administration and/or medical treatment plan.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name: _____

Address: _____

Email Address: _____

Home Phone #: _____

Alternate Phone #: _____

Emergency Contact Name: _____

Phone #: _____

PARENT/GUARDIAN AUTHORIZATION FOR STUDENT TO SELF-ADMINISTER AND/OR SELF-CARRY EMERGENCY MEDICATION (if applicable)

(Asthma medication, Epinephrine injector, Diabetic management medication, or Seizure emergency medication)

I further, authorize Yorkville Community Unit School District 115 and its employees and agents, to allow my child to self-carry and/or self-administer their prescribed asthma medication, epinephrine injector, diabetic management medication and/or seizure emergency medication required under a qualifying plan: asthma action plan, Individual Health Care Action Plan, an Allergy Emergency Plan and Treatment Authorization Form, a plan pursuant to the federal Individuals with Disabilities Education Act, diabetes care plan, or seizure action plan (105 ILCS 5/10-22.21b, 105 ILCS 145/, 105 ILCS 150/).

I hereby verify that my licensed healthcare provider has instructed my child in the proper self-administration of the medication.

I agree to indemnify and hold harmless the School District, its Board of Education, Board members, offices, employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of emergency asthma, allergy, diabetes medication, and seizure medication to my child.

I understand that the School District and its employees and agents shall incur no liability, except for willful and wanton conduct, related to the care of a student with diabetes, a student with seizures or as a result of an injury arising from a student's self-carry and self-administration of an epinephrine injector or asthma medication.

Parent/Guardian Signature

Date

Order Reviewed by School Nurse: _____

Date: _____