

SPECIAL EDUCATION DISTRICT OF LAKE COUNTY

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www.sedol.us



Dr. Jennifer Thomas
Superintendent

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# _____