Bannockburn School District 106
Medication Authorization

A new form must be completed every school year. Multiple medications each require their own form.

Student Name: _____ Date of Birth:_____

Address: _____ Phone: _____

To be completed by the student's physician, physician assistant, or advanced practice nurse

Medication Name: _____ Dose: _____ Route:_____

Time, frequency, or circumstances, medication is to be administered at school:

_____

Diagnosis requiring medication:_____ Purpose:_____

Possible side effects: _____

Other medication student is receiving:_____

Physician Name: _____ **Phone:** _____

Physician Address: _____ **Fax:** _____

Physician Signature: _____ **Date:**_____

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 the School District 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, while under the supervision of the employees and agents of the School District), 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 the School District 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 Parent/Guardian printed name

_____ _____
Parent/Guardian signature* Date Parent/Guardian signature* Date

- Both parents and/or guardians, if available, should sign.

Bannockburn School District 106
Self-Administration Medication Authorization

A new form must be completed every school year. A separate form must be completed for multiple medications.

I give permission for my child _____ to carry and self administer the medication described below.

Name of Medication: _____

Dose: _____

Under what circumstance should student take medication:_____

For epinephrine autoinjectors: the parent must also provide either a medication permission form or an anaphylaxis emergency plan signed by the physician, physician assistant, or advanced practice nurse.

For asthma medication: the parent must provide a copy of the prescription label of the medication. The label must include the medication name, the dose, and the circumstances under which the medication is taken.

I authorize the School District and its employees and agents to allow my child or ward to possess and use his or her asthma medication and/or 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 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-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree, please sign:

_____ _____
Parent/Guardian printed name Parent/Guardian printed name

_____ _____
Parent/Guardian signature* Date Parent/Guardian signature* Date

*Both parents and/or guardians, if available, should sign.