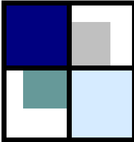

Special Services for District 92

710 N. State Street, Lockport, Illinois 60441
Phone: 815-836-7719 - Fax: 815-838-1758

Kimberly West, Assistant Superintendent for Special Education

Students

School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Principal's office.

Student's Name: ______________________ Birth Date: __________

Address: ______________________

Home Phone: ______________________ Emergency Phone: __________

School: ______________________ Grade: ______ Teacher: __________

*To be completed by the student's physician, physician assistant, dentist, optometrist, podiatrist, or advanced practice RN (***Note***: for asthma inhalers only, use the* "Asthma Inhalers" *section on the back of this page):*

Physician's Printed Name: ______________________

Office Address: ______________________

Office Phone: ______________________ Emergency Phone: __________

Medication name: ______________________

Purpose: ______________________

Dosage: Frequency:

Specific individual(s) who may administer the medication to the student when a School Nurse or RN is not available:

____

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

____

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:

Actions to be taken if the student has side effects and/or an adverse reaction to the medication:

____

Time interval for re-evaluation: ______________________

Other medications student is receiving: ______________________

____

Physician's signature Date

PLEASE COMPLETE BOTH SIDES

02/19

Asthma Inhalers

Parents/Guardians: Please also fill out the *Parent Authorization and Student Agreement to Carry and Self-Administer Medication or Health Procedure* form.

A written statement from the student's physician, physician assistant, dentist, optometrist, podiatrist, or advanced practice RN is not required for a student to carry and self-administer an asthma inhaler. Parent(s)/Guardian(s) must attach the prescription label here, which must include the name of medication, the prescribed dosage, and the time at which/circumstances under which the medication is to be administered:

[Attach prescription label here]

For only parents/guardians authorizing students to carry asthma medication or an epinephrine auto-injector:

I authorize School District 92 and its employees and agents to allow my child to carry and self-administer his or her asthma inhaler and/or use his or her 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. I hereby acknowledge that School District 92, its officials, employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by my child regardless of whether authorization was given by me or by my child's physician, physician's assistant, dentist, optometrist, podiatrist, or advanced practice register nurse. **I hereby agree to indemnify and hold harmless School District 92, its officials, employees, and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication or use of an epinephrine auto-injector by my child regardless of whether authorization was given by me or by my child's physician, physician's assistant, dentist, optometrist, podiatrist, or advanced practice register nurse.** (105 ILCS 5/22-30).

Print Parent/Guardian Name: ____________________

Parent/Guardian 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 School District 92 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* pursuant to State law, while under the supervision of the employees and agents of School District 92), 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 School District 92 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the self-administration of medication by my child.**

____

Parent/Guardian printed name

Address (if different from Student's above): ____________________

Phone: ____________________ Emergency Phone: ____________________

____________________ __________

Parent/Guardian signature Date

02/19