STUDENTS

Exhibit - School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office:

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

To be completed by the student's physician or parent:

Physician's Printed Name:		
Office Address:		
Office Phone:	Emergency Phone:	
Name of Medication:		
Dosage:	Frequency:	Time to be given in school:
Does medication require refrigeration? □ Yes □ No		
Date of prescription:	Date of order:	Discontinuation Date:
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medication condition?		□ Yes □ No
Potential side effects, if any:		
Time interval for re-evaluation:		
Other medications student is receiving:		

For parent(s)/guardian(s) of students who have asthma:

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 (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 (105 ILCS 5/22-30).

If you agree please initial: _____

Parent(s)/Guardian(s) initial

By signing below, I agree:

1. 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 and stead, 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**. I also agree to: (1) deliver the medication to the school; (2) notify the school if the medication, the dosage, or the procedures are changed, or to be eliminated.
2. To hold harmless and indemnify the School District, its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

Parent(s)/Guardian(s) signature*:
Parent(s)/Guardian(s) name (please print)
Date:

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

ADOPTED: October 6, 1992

REVISED: January 22, 2002