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 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, physician assistant, or advanced practice RN (Note: for asthma inhalers only, use the "Asthma Inhalers" section below):

Physician's Printed Name:		
Office Address:		
Office Phone:	Emergency Phone:	
Medication:		
Purpose:		
Dosage:	Frequency:	
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:		
Time interval for re-evaluation:		
Other medications student is receiving:		

Physician's signature _____ Date _____

Asthma Inhalers

Parent(s)/Guardian(s), please attach prescription label here:

For only parents/guardians of students who need to carry asthma medication or an ~~EpiPen®~~ epinephrine auto-injector:

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 initial: _____

Parent(s)/Guardian(s) initial

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 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.*