Frankfort

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 157-C

School Medication Authorization Form – Page 1 of 2

**** WE REQUIRE ONE FORM FOR EACH MEDICATION KEPT AT SCHOOL ****

Student's Name: ____ Birth Date: ___________________________

Address: ____

Home Phone: _______________________________________ Emergency Phone: _______________________________________

School: _________________________________ Grade: ______________________ Teacher: _____________________________

*** TO BE COMPLETED BY STUDENT'S PHYSICIAN (UNLESS IT IS FOR AN INHALER) ***

Physician's Printed Name: ____

Office Address: ____

Office Phone: ______________________________ Emergency Phone: _____________________________

Name of Medication: ____

Dosage: ____________________ Frequency: ____________________ Route: ____________________

Date of Order: _____________________________ Time/Given in School: ___________________________

Discontinuation Date: _______________________ Date of Prescription: _____________________________

Diagnosis requiring medication: ____

Is it necessary for this medication to administered during the school day? Yes ☐ ☐ No

Expected side effects, if any: ____

Other medication(s) student is receiving:

____

____

*Allergies: ____

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

____ _______________________________

Physician's Signature Date

<u>Asthma Inhalers</u>

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

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School Medication Authorization Form – Page 2 of 2

For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:
I authorize the School District and its employees and agents, to allow my child or ward 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. 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 choose to have your child carry their inhaler/epinephrine, we recommend that you provide an additional inhaler/epinephrine to be kept at school in the health office in the event that your child forgets or loses his/her medication.**

If you agree please initial: ___________________________________

For all parents/guardians:
I confirm 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 Frankfort School District 157-C and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child pursuant of State law (or 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 further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

____   _______________________________
Parent/Guardian Signature   Date

____
Parent/Guardian Printed Name

Phone: ____   Emergency Phone: ______________________________

Address (if different from Student's address): ____