

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

Asthma Inhalers

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



COMMUNITY CONSOLIDATED SCHOOL DISTRICT 157-C

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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 (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): _____