HARVARD COMMUNITY UNIT SCHOOL DISTRICT #50
MEDICATION AUTHORIZATION FORM  (revised 5/2016)
401 North Division St, Harvard Il 60033  Phone 815-943-4022 Fax 815-943-8511

Fill out only if taking medication at school.

Exhibit - Student Medical Authorization Form 1, 2

(Required when a student needs to take prescription or non-prescription medication at school.)

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 name: _________________________________________
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 ___________

1 This exhibit may be placed in the handbook or given to parents/guardians as needed.

1 Students who are diabetic may also self-carry and self-administer diabetic testing supplies and insulin. Diabetic students must have a separate Diabetes Care Plan. For further information, see: www.iasd.com/laaw/diabetes.cfm, Handbook Procedure 1.130 (Care of Students with Diabetes) and Handbook Procedure 1.130-E1 (Exhibit: Authorization to Provide Diabetes Care, Release of Health Care Information, and Acknowledgement of Responsibilities).
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 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).

Please initial below to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian initials

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 pursuant to State law, 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 administration or the child’s self-administration of medication.

Parent/Guardian printed name

Address (if different from Student’s above): ____________________________

Phone: ____________________________ Emergency Phone: ____________________________

Parent/Guardian signature ____________________________ Date ____________________________

Additional information: ____________________________