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 with prescriptive authority, or advanced practice RN with prescriptive authority.

NOTE: *A Doctor's order is no longer needed for inhalers. For inhalers, parents use the "Asthma Inhalers" section below and complete top and bottom of second page:*

Prescriber'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: _____

_____
Prescriber's Signature Date

Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label from the inhaler box here:

All parents please complete second page:

ADOPTED: January 17, 2019

For only parents/guardians of students who need to carry asthma medication or an epinephrine 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 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 inury arising from a student's self-administration of medication or epinephrine injector (105 ILCS 5/22-30).

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine 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. This includes administration of undesignated epinephrine injectors or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not. (105 ILCS 5/22-30, amended by P.A. 99-480).**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

ADOPTED: January 17, 2019

Richland County Community Unit District #1
Authorization For Release of Information

I authorize the Richland County School District #1 to release/obtain:

_____ 1. Health records (physical and/or dental examinations, immunizations, etc.)

_____ 2. Psychological and/or social work reports and information.

_____ 3. Special Education records (case study evaluation results, IEP's, conference and/or teacher reports, etc.)

_____ 4. Other information _____

Regarding _____ _____
Student's Name Date of Birth

to/from _____
Physician/Facility/Agency

_____
Address

for the purpose of facilitating health services. Consent is valid until calendar date _____. Failure to provide consent to release information may result in the following:
_____

_____

_____

I understand that the above named Physician/Facility/Agency authorized to receive this information has the right to inspect and copy the information to be disclosed. I understand this consent is valid for one year from the date of signature below if not otherwise noted. I understand that I may revoke this consent at anytime (revocation must be in writing). I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications that has already been acted upon.

_____ _____
Recipient (age 12 or older) Date

_____ _____
Parent/Guardian of minor or legally disabled recipient Date

_____ _____
Witness Date

NOTICE TO RECEIVING PHYSICIAN/FACILITY/AGENCY: You may not disclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. As under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act (II. Rev. Stat., ch. 91 ½, par. 901 et seq.)

Rev. 16/06