ILLINI BLUFFS SCHOOL DISTRICT #327

HOME OF THE TIGERS

2023-2024 Medication Authorization Form

Student's Name: _____ Grade: _____ *(for 23-24)* School: *(Circle)* IBES IBMS IBHS

Non-prescription medications: _____

Reason for medication: _____

Prescription Medication to be completed by the child's physician, physician assistant, or advanced practice RN:

Physician's Printed Name: _____ Physician's Address: _____

Office Phone: _____ Office Fax: _____

Medication Name: _____ 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? *(Circle)* YES NO

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Physician's Signature and date: _____

For 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 indicating receipt of this information and authorization for your child to carry and use his/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 Signature: _____