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.iasb.com/law/diabmats.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: