Okaw Valley C. U. S. D. #302
School Medication Authorization Form

To be completed by the student's parent(s)/guardian(s) and filed at student's school building

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:

Physician's Printed Name:_____

Office Address:_____

Office Phone:_____ Emergency Phone: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

_____

Prescription Date: _____ Order Date :_____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Intended effect of medication: _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? ☐ Yes ☐ No

Expected side effects, if any: _____

Time interval for re-Evaluation:_____

Other medications the student is receiving: _____

Physician's Signature:_____ Date: _____

School Medication Authorization

For only parent(s)/guardian(s) of students who need to carry asthma medication or an EpiPen:

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication and/or 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 (105 ILCS 5/22-30)

If you agree please initial: _____
Parent(s)/Guardian(s) initial

For all parents/guardians:

1. 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 Okaw Valley C. U. S. D. #302 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to 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 will 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**

2. 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 self-administration of medication by the pupil.

Parent(s)/Guardian(s) printed name: _____

Parent(s)/Guardian(s) signature: _____

Date: _____