PRESCRIPTION MEDICATION AUTHORIZATION FORM

This form is only good for ONE school year
2023-2024 School Year

This form must be signed by your PHYSICIAN for all PRESCRIPTION medications to be given at school.

Student's Name: _____ D.O.B: _____
Teacher: _____ Grade: _____
Home phone: _____ Emergency Phone: _____

Name of Medication: _____
Purpose/Diagnosis requiring medication: _____
Dosage: _____ Frequency: _____
Time medication is to be administered or under what circumstances: _____
_____
Prescription date: _____ Order date: _____ Discontinuation date: _____

If INHALER is prescribed, is it to be carried on the person: YES/ NO
or can it be stored in the health center: YES/ NO
Expected side effects, if any: _____ Time interval for re-evaluation: _____

Physician's Name (please print): _____
Physician's Address: _____
Physician's Phone: _____ Physician's Fax: _____
Physician's Signature: _____ *Date*: _____

Only 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 possess and use his/her asthma medication and/or epinephrine auto-injector **(1)** while at school, **(2)** while at a school0sponsored activity, **(3)** while under the supervision of the 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 and/or epinephrine auto-injector (105 ILCS 5/22-30)

If you agree, please initial: _____

By signing below, I agree:
1. 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 108 School District 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 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.** I also agree to: **(1)** deliver the medication to the school; **(2)** notify the school if the medication, the dosage, or the procedures are changed, or to be eliminated.
2. To hold harmless and indemnify the School District, its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication be the pupil.
3. I understand that I must provide all medication in the original bottle, with the student's first and last name written on the bottle. I understand that medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. I also understand that my signature allows for verbal communication as necessary between the school nurse and the above prescriber to ensure safe administration of all medication marked above.
Parent/Guardian Printed Name: _____
Signature: _____ *Date :* _____