Millstadt Community Consolidated School District #160

Sandi Pegg – Principal
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Ed Emge – Assistant Principal
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School Medication Authorization Form

Required when students need to take prescription or non-prescription medications at school.

Student's Name: _____ Date of Birth: _____
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 on the back******

Physician's Printed Name: _____
Office Address: _____
Office Phone: (___)_____ Emergency Phone: (___)_____

Medication Name: _____ Dosage: _____
Time: _____ Frequency:_____
Route:_____
****If PRN, please include indications for administering medication:**
_____
Diagnosis for Medication: _____
Prescription Start Date: _____ Discontinuation date: _____
Expected side effects (if any):
_____
Time interval for reevaluation:
_____
Is it necessary for the student to receive this medication during the school day? Yes __ No__

_____ _____
Physician/Provider Signature *Date*

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PARENTS/GUARDIANS MUST COMPLETE THE BACK SIDE AUTHORIZATION SECTION

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.* ***I have read the policy and procedures for administration of medication in Millstadt School District 160 and agree to abide by them.***

*****I will provide the Health Office with a current Action Plan for my child's condition*****

_____ _____

Signature of Parent/Guardian Date

NO MEDICATION WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.

Asthma and/or EpiPen Medication Authorization

Student's Name: _____ Date: _____

I authorize MCCSD #160 and its employees and agents to allow my child or ward to carry and self-administer his/her asthma inhaler and/or use his/her epinephrine auto-injector

- While in school
- While at a school-sponsored activity
- While under the supervision of school personnel
- Before and/or after normal school activities, such as while in before-school or after-school care on school-operated property.

_____ _____

My signature allows my student to self-carry their inhaler/EpiPen Date

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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)