Sullivan Community School District #300
725 N. Main St. Sullivan, IL 61951
217-728-8341
Elementary Fax# 217-728-4399 Middle School Fax# 217-728-4296 High School Fax# 217-728-4139

To be completed by the parent/guardian(s) and kept on file in the school nurse's office, or in the absence of a school nurse, the Building Principal's office.

Student Name: _____ Birth Date: _____
Address: _____
Primary Phone: _____ Emergency Phone: _____
Grade: _____ School: _____ Teacher: _____

To be completed by the student's physician:

Name of Medication: _____
Dosage: _____ Frequency: _____ Time to be given in school: _____
Prescription Date: _____ Discontinuation Date: _____ Date of Order: _____
Diagnosis requiring medication: _____
Intended effect of this 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 Printed Name: _____
Office Address: _____**Office Phone:** _____

Physician's Signature: _____Date:_____

School Medication Authorization

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, on 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, and 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) Signature: _____
Parent(s)/Guardian(s) Printed Name: _____
Date: _____

For parents/Guardians 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/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 concur, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

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