# ALBERS ELEMENTARY SD #63

206 North Broadway, PO Box 104
Albers, Illinois 62215-0104
(618) 248-5146 Fax (618) 248-5659


## School Medication Authorization Form

Student's Name_____ Date of Birth: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

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: _____

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***

***For only 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 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 or epinephrine auto-injector.(105 ILCS 5/22-30). **If you agree please initial: _____**

***For all parents/guardians:***

By signing below, I agree that I am primarily responsible for administrating 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 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 be an individual other that 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 based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

| | |
|---|---|
| _____ | _____ |
| Parent / Guardian printed name | Parent / Guardian printed name |
| _____ | _____ |
| Parent / Guardian signature* Date | Parent / Guardian signature* Date |

**Both parents and/or guardians, if available, should sign.*