

Wesclin Community Unit School District #3

School Medication Authorization Form

Required when a prescription or non-prescription medication needs to be taken at school. A new form must be completed every school year.

Student's Name: _____ Birth Date: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Emergency Phone: _____
School: _____ Grade: _____ Teacher: _____

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:

Prescriber'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: _____
Prescriber's Signature _____ Date _____

Please note: **This authorization form contains two pages. Both pages must be reviewed and signed before submission.**

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Students Name: _____

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, on 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. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication, to the extent the School District maintains such undesignated supplies, to my child when there is a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on-site or has expired. 105 ILCS 5/22-30, amended by P.A. 102-413.; 105 ILCS 145/27, added by P.A. 101-428. **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.

Parent/Guardian Signature: _____ Date: _____

For parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:

Self Carry Authorization

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine 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 parents/guardians 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-carry and self-administration of asthma medication or epinephrine injector. 105 ILCS 5/22-30, amended by P.A. 102-413.

Please initial below to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian initials

Please return this form to the school signed by the licensed health care provider, and the parent/guardian. **NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER) WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.**