Wesclin Community Unit School District #3

School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s).

A new form must be completed every school year for each medication. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

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 of 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.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____ Date:_____

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

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 sign to indicate (1) receipt of this information, and (2) authorization for your child to carry and use his or her asthma medication or epinephrine injector.

_____

Parent/Guardian Signature

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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 .