

**Students**

**Exhibit - School Medication Authorization Form**

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

*This form is to be used for medication other than medical cannabis. (See 7:270-E2, School Medication Authorization Form - Medical Cannabis.) A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.*

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 (Note: for asthma inhalers only, use the **Asthma Inhalers** section below):*

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

**Asthma Inhalers**

*Parent(s)/Guardian(s) please attach prescription label here:*

***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 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-carry and self-administration of asthma medication or epinephrine -injector. 105 ILCS 5/22-30, amended by P.A.s 100-726 and 100-799, eff. 1-1-19.

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

\_\_\_\_\_  
Parent/Guardian Initials

***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 or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff. 1-1-19. **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 Printed Name

Address (if different from Student's above): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Approved: May 2019