AUTHORIZATION FOR ADMINISTRATION OF MEDICATION 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-#2, School Medication Authorization Form- Medical Cannabis). **A new form must be completed every school year for each medication.**

Student's Name_____Birth Date: _____

Address:_____

Home Phone:_____Cell Phone: _____ Emergency Phone:_____

School (Please Circle) Elementary School Jr/Sr High 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 Phone:_____

Office Address: _____

Medication Name:_____

Purpose:_____

Dosage _____ Frequency: _____

Time medication is to be administered and/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: _____

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 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 Pas 100-726 and 100-799; 105 ILCS 145/27, added by PA 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 Printed Name:_____

Address (if different from Student's) _____

Parent/Guardian Signature_____ Date _____