



### School Medication Authorization Form

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

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
School: \_\_\_\_\_ 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:*** \_\_\_\_\_  
Parent(s)/guardians(s)

***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, in my behalf, to administer or to attempt to administer to my child (or to 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 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

\_\_\_\_\_  
Parent/Guardian printed name

\_\_\_\_\_  
Parent/Guardian signature\*      Date

\_\_\_\_\_  
Parent/Guardian signature\*      Date

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