

## School Medication Authorization Form

*To be completed by the student's parent/guardian. A new form must be completed each school year. Please complete one form per medication. Medications must be brought to the school office in the original container.*

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

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

*To be completed by the student's physician.*

Physician's Name (printed): \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time medication is to be administered at school or under what circumstances: \_\_\_\_\_

Prescription Date: \_\_\_\_\_ Order Date: \_\_\_\_\_

Discontinuation Date: \_\_\_\_\_

Expected Side Effects (if any): \_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Parents must also complete the next page***

**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 \_\_\_\_\_ 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 , while under the supervision of the employees and agents of \_\_\_\_\_), lawfully prescribed medication in the manner described above, or over-the-counter medication that has been brought in by the student in the manner indicated on the container.

I acknowledge that \_\_\_\_\_ does not have a school nurse. I agree to indemnify and hold harmless \_\_\_\_\_ and its employees and agents against any and all claims, except a claim based on willful and wanton misconduct, arising out of the administration or the child's self-administration of medication.

If you agree, please initial: \_\_\_\_\_  
Parent/guardian

**For parents/guardians of students who need to carry asthma or diabetes medication or an epinephrine auto-injector:**

I authorize \_\_\_\_\_ and its employees and agents, to allow my child to possess and use his/her asthma or diabetes medication and/or epinephrine auto-injector while in school. Illinois law requires \_\_\_\_\_ to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton misconduct, 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/guardian

**All parents must sign below:**

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date