STREATOR ELEMENTARY SCHOOLS DISTRICT #44
SCHOOL MEDICATION AUTHORIZATION FORM

A new form must be completed every school year and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

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

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: _____

Intended effect of this medication: _____

Is it necessary for this medication to be administered during the school day? □ YES □ NO

For asthma medication or an EpiPen®, will the student self carry medication? □ YES □ NO

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____

Physician's Signature Date

(This form must be signed by a physician or person authorized to prescribe medication. A Doctor/Nurse signature is not acceptable.)

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For only parent(s)/guardian(s) of students who need to carry asthma medication or an EpiPen®:

I authorize District #44 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 and 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 (105ILCS 5/22-30).

If you agree please initial: _____
Parent(s)/Guardian(s) initial

For all parent(s)/guardian(s) of students who need medication, by signing below, I agree:

1. 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 District #44 and its employees and agents, in my behalf and stead, 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 District #44), 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

2. To indemnify and hold harmless District #44 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

_____ _____
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.