SCHOOL MEDICATION AUTHORIZATION FORM

Student's Name ____ Birthdate ____________________

Address ____ Home Phone _________________

School ____ Grade ________ Teacher _____________________

Emergency Phone No. ______________________________

To be completed by the student's physician or parent:

Name of Medication ____

Dosage ____ Time _______________________

Duration of Administration ____

Type of Illness or Disease ____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition?

____

Side Effects To Be Alert To:

____

____ ____________________________________

Doctor's Name - Print Date

____ ____________________________________

Address Phone

Further Instruction Remarks: ____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Midlothian School District #143 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 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 or health aide, and specifically consent to such practices.***

SCHOOL MEDICATION AUTHORIZATION FORM

I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

________________________________ ________________________________

Parent/Guardian Signature Date

<u>FOR OFFICE USE ONLY</u>

____

(Person Obtaining Permission) By Phone

____

(Person Granting Permission) By Phone

________________________________ ________________________________

Time Date

POLICY ON ADMINISTERING MEDICINES TO STUDENTS

<u>Administering Medicines to Student</u>

Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parent(s)/guardian(s) believe that it is necessary for the student to take a medication during school hours, they must request that the school dispense the medication to their child/ward and otherwise follow the District's procedures on dispensing medication.

No School District employee shall or supervise a student's self-administration of, any prescription or non-prescription medication until a completed and signed "School Medication Authorization Form" is submitted by the student's parent(s)/guardian(s). No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures. A student may possess medication prescribed for asthma and/or allergy for immediate use at the student's discretion, provided the student's parent(s)/guardian(s) have completed and signed a "School Medication Authorization Form." The School District shall 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 the medication's storage by school personnel. Parent(s)/guardian(s) must 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 a student's self-administration of medication or the storage of the medication by school personnel.

Nothing in this policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

The Building Principal shall include this policy in the Student Handbook and shall provide a copy to the parent(s)/guardian(s) of students.

LEGAL REF.: 105 ILCS 5/10-20.14b, 5/10-22.21b, and 5/22-30

PARENTAL AUTHORIZATION
SELF-MEDICATION OF ASTHMA AND/OR ALLERGY (epi-pen) MEDICATION

Student's Name ____ Birthdate ______________________

School ____ Grade _________ Teacher _______________________

The following guidelines shall apply to the self-administration of a student's asthma and/or allergy medication:

- Physician/Prescriber signed dated authorization to administer the medication, setting forth the name and purpose of the medication, the prescribed dosage, time for administration, and any other special related information to the administration.
- Parent/Guardian signed, dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, name of the medication, directions for use, and date.
- Annual renewal of authorization and immediate notification, in writing, of changes.
- The District and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.

PARENTAL AUTHORIZATION

I hereby acknowledge that I am the parent and/or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize Midlothian District #143 to allow my child to self-administer his/her lawfully prescribed asthma and/or allergy medication during the following: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, and (4) before or after normal school activities.

I further acknowledge and agree that the District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma and/or allergy medication. I further acknowledge and agree that, in the absence of willful and wanton conduct on the part of the District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless the District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parities, from and against any and all claims, damages, causes of action, or injuries incurred or resulting from my child's self-administration of said medication.

Parent/Guardian Signature____ Date______________________________

Home Phone___________________________________ Business Phone_______________________________________

Parent/Guardian Signature____ Date______________________________

Home Phone___________________________________ Business Phone_______________________________________

PHYSICIAN AUTHORIZATION AND REQUEST
FOR SELF-ADMINISTRATION OF ASTHMA AND/OR ALLERGY (epi-pen) MEDICATION

Student's Name ____ Birthdate ______________________

Address ____ Phone Number_________________________

Emergency Contact Person and Phone ____

TO: PRINCIPAL ____

SCHOOL ____

The above-named pupil has (name of asthma and/or allergy condition)____

I am requesting that the above-named student take the following medication as prescribed below during school hours (including before or after normal school activities, while in a school-sponsored activity, and while under the supervision of school personnel):

Name and Type (tablet, liquid, capsule) of Medication ____

Purpose of Medication ____

Dosage ____ Times to be Administered _____________________________

Special circumstances under which medication is to be administered ____

____

Possible side effects ____

I certify that ___________________________________(name of student) has been instructed in the use and self-administration of ____(name of medication). He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Prescriber's signature____ Date _____________________________

Print Name of Prescriber ____

Prescriber's Emergency Phone Number _________________________________

Prescriber's Address ____

FOR OFFICE USE ONLY

Person obtaining permission by phone____

Person granting permission by phone____

Time :____ Date :____________________________