7:270-E1 – Exhibit - 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 Principal's office:*

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Student I.D.:

To be completed by the **student's physician, physician assistant, or advanced practice RN**:

*(**Note**: for asthma inhalers only, use the **Asthma Inhaler** section below.)*

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?		
Expected side effects, if any:		
Time interval for re-evaluation:		
Other medications student is receiving:		
Physician's Signature:		Date:

Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label here:

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

I authorize the School District and its employees and agents, to allow my child or ward to self-carry and self-administer 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-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30).

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

_____

Parent/Guardian Initial

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 auto-injectors or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **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 above): _____

Phone: _____ Emergency Phone: _____

_____ _____

Parent/Guardian signature *Date*

DATED: 05/15

REVISED: 11/13/17; 11/27/17

GLENBARD WEST HEALTH SERVICES FAX- 630-942-7559