

MEDICATION AUTHORIZATION FORM
COMPLETE ONLY IF STUDENT NEEDS MEDICATION DURING SCHOOL HOURS

Student's Name _____ Birth Date _____

School/Teacher _____ Grade _____

To be completed by student's physician:

Name of Medication _____ Dosage _____

Frequency _____ Dosage Times _____

Date of Prescription _____ Discontinuance Date _____

Diagnosis requiring medication _____

Intended effect of this medication _____

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?

_____ YES _____ NO

May student self-administer medication under supervision of school personnel? (Note that it is the District's policy **not** to administer medications to students except in emergency situations.)

_____ YES _____ NO

If this prescription is for an inhaler, should the student carry the inhaler on his/her person?

_____ Yes _____ No

Instructions for self-administering _____

Emergency conditions under which medications should be administered, including directions for administration by other school personnel. _____

Expected side effects, if any _____

Other medications the student is receiving _____

Physician's Signature _____ Physician's Name _____

Date _____ Address and Phone _____

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PLEASE READ THIS DOCUMENT CAREFULLY AS YOU ARE WAIVING
CERTAIN LEGAL RIGHTS YOU MAY OTHERWISE HAVE

RELEASE AND HOLD HARMLESS FOR MEDICATIONS

To be completed by Parent or Guardian:

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event of a medical emergency, or if necessary, for the critical health and well-being of my child, I hereby authorize the **NEW LENOX SCHOOL DISTRICT** and its employees and agents, on my behalf and stead, to administer or to attempt to administer medication to my child during school hours.

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.

I understand that my child is expected to be compliant in the medication treatment plan as ordered by the physician. I further acknowledge and agree that, when lawfully prescribed medication(s) is so administered or attempted to be administered or is self-administered by my child, I waive any claims I might have against the School District, release and hold the District, its employees and agents either jointly or severally, harmless 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.

I further represent to the School District that my child ___ is ___ is not (check one) capable of self-administering the medication.

I authorize the school nurse to talk with the prescribing physician by phone about the medication if needed.

Parent Name

Phone Number

Parent Signature

Date

For parent(s)/guardian(s) of students with physician permission to carry inhalers:

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 (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, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

If you agree please sign:

Parent(s)/Guardian(s) signature