Two-sided form

MAERCKER 60 SCHOOL DISTRICT

Tradition ◆ Inspiration ◆ Excellence

MEDICATION AUTHORIZATION FORM

Student's Name_____ Grade in School_____ Birth Date_____

THE FOLLOWING IS TO BE COMPLETED BY THE STUDENT'S PHYSICIAN
(or, if for self-administration of asthma medication only, this form may be completed by parent/guardian)

Name and Purpose of Medication: _____

_____

Date of Doctor's Order: _____ Date of Prescription: _____

Dosage: _____ Discontinuation Date: _____

Time(s) medication is to be administered or under what circumstances: _____

_____

Is this medication considered a non-prescription medication? _____YES _____NO

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

May the child self-administer this medication with or without adult supervision? _____YES _____NO

Special storage requirement for this medication, if any: _____

How is this medication to be administered? _____

Diagnosis Requiring Medication: _____

Expected Side Effects, if any: _____

Other Medication Student is Receiving: _____

_____	_____	_____
Physician's Name – Print	Physician's Signature	Physician's Phone #

If for administration of asthma medication:

_____	_____	_____
Parent/Guardian's Name – Print	Parent/Guardian's Signature	Parent/Guardian phone #

Parents/Guardians **attach prescription label here:**
(Note: prescription label must include the following information: name of medication, prescribed dosage and the time at which or circumstances under which the medication is to be administered.)

For Administration of Epinephrine Auto-injector: **2 Auto-injectors are required**

Continued on other side →

I confirm 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 Maercker School District #60 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, and specifically consent to such practices.**

I authorize Maercker School District #60 and its employees and agents, to allow my child or ward to carry and self-administer his/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/guardian 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 or epinephrine auto-injector regardless of whether the authorization was provided by you or the child's physician. (105 ILCS 5/22-30.)**

I agree to hold harmless and indemnify Maercker School District #60, its employees and agents, either jointly or severally, from and against any claims, except a claim based upon willful and wanton conduct, arising out of the administration or the child's self-administration of asthma medication, use of an epinephrine auto-injector or other medication regardless of whether this authorization was provided by you or the child's physician, physician's assistant, or advanced practice nurse.

Parent or Guardian Signature	Date	Home Phone #	Emergency Phone #

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