School Medication Authorization Form

Please note: This form will be in effect for the school year in which it is submitted. A new form must be completed every school year for each medication.

Section 1 - To be completed by the child's parent/guardian.

Student's Name: _____ Birth Date: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Emergency Phone: _____
School: _____ Grade: _____ Teacher: _____

Does the student require medication under an Asthma Action Plan, an Individual Health Care Action Plan, a Food Allergy Emergency Action Plan, a Section 504 Plan, or an IEP? ☐ Yes ☐ No

If the answer to the question is yes:

- Is the student authorized to self-administer the medication? ☐ Yes* ☐ No
- If the medication is asthma medication or an epinephrine injector, is the student authorized to self-carry the asthma medication or epinephrine injector? ☐ Yes* ☐ No

*Please note that for all medication other than asthma medications, authorization from the student's physician, physician assistant, or advanced practice registered nurse is also required.

Section 2 - To be completed by the student's physician, physician assistant, or advanced practice registered nurse.

Medication Name: _____
Purpose: _____
Dosage: _____ Frequency: _____
When medication is to be administered (time or under what circumstances): _____
Prescription date: _____ Order date: _____Discontinuation date: _____
Diagnosis requiring medication: _____
Is it necessary for this mediation to be administered during the school day? _____
Expected side effects if any: _____
Time interval for re-evaluation: _____
Prescriber's Printed Name: _____
Office Address: _____
Office Phone: _____ Emergency Phone: _____

If the medication is required under an Asthma Action Plan, an Individual Health Care Action Plan, a Food Allergy Emergency Action Plan, as Section 504 Plan, or an IEP:

- Is the student authorized to self-administer the medication? ☐ Yes ☐ No
- Is the student authorized to self-carry the medication? ☐ Yes ☐ No

Prescriber's Signature: _____ Date: _____

Medication Name: _____
Purpose: _____
Dosage: _____ Frequency: _____
When medication is to be administered (time or under what circumstances): _____
Prescription date: _____ Order date: _____Discontinuation date: _____
Diagnosis requiring medication: _____
Is it necessary for this mediation to be administered during the school day? _____
Expected side effects if any: _____
Time interval for re-evaluation: _____
Prescriber's Printed Name: _____
Office Address: _____
Office Phone: _____ Emergency Phone: _____

If the medication is required under an Asthma Action Plan, an Individual Health Care Action Plan, a Food Allergy Emergency Action Plan, as Section 504 Plan, or an IEP:

- Is the student authorized to self-administer the medication? ☐ Yes ☐ No
- Is the student authorized to self-carry the medication? ☐ Yes ☐ No

Prescriber's Signature: _____ Date: _____

Medication Name: _____
Purpose: _____
Dosage: _____ Frequency: _____
When medication is to be administered (time or under what circumstances): _____
Prescription date: _____ Order date: _____Discontinuation date: _____
Diagnosis requiring medication: _____
Is it necessary for this mediation to be administered during the school day? _____
Expected side effects if any: _____
Time interval for re-evaluation: _____
Prescriber's Printed Name: _____
Office Address: _____
Office Phone: _____ Emergency Phone: _____

If the medication is required under an Asthma Action Plan, an Individual Health Care Action Plan, a Food Allergy Emergency Action Plan, as Section 504 Plan, or an IEP:

- Is the student authorized to self-administer the medication? ☐ Yes ☐ No
- Is the student authorized to self-carry the medication? ☐ Yes ☐ No

Prescriber's Signature: _____ Date: _____

Section 3 – Parent/Guardian Signatures

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 injectors, opioid antagonists, or asthma medication to my child when there is a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma

episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on- site or has expired. 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 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 of medication to a student or the self-administration of medication by a student.

Parent/Guardian Printed Name: _____

Address (if different from student's address above): _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

Parent/ Guardian Signature: _____ Date: _____

For only parents/guardians of students who need to self-carry and/or self-administer medication required under a qualifying plan:
I grant permission for my child to self-administer his or her medication required under an Asthma Action Plan, an Individual Health Care Action Plan, a Food Allergy Emergency Action Plan, a Section 504 Plan, or an IEP. I understand that, pursuant to applicable law, the School District and its employees and agents shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-carry and self-administration of medication by the student.

☐ Not Applicable

☐ Yes - Sign and date: _____ _____

Parent/Guardian Signature Date

For only parents/guardians of students who need to carry and use their asthma medication:
I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer 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. I understand that pursuant to Illinois law, the School District and its employees and agents, shall 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. I also agree to provide the School District the prescription label, which must contain the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

☐ Not Applicable

☐ Yes - Sign and date: _____ _____

Parent/Guardian Signature Date

Section 4 - Requirements for additional documentation and delivery of medication.

General Procedures (for students not authorized to self-carry medication or an epinephrine injector)
Medication to be administered during the school day must be brought to the school by the student's parent/guardian.

Medication is not to be sent to school with the student and cannot be given to a bus driver or bus aide for delivery to school. On the rare occasion when a parent/guardian is unable to deliver medication to the school during regular business hours, the parent/guardian should contact the school office to make arrangements for an alternate time.

Prescription medication must be brought to school in the original package or appropriately labeled container. The container must display:

- Student's name
- Prescription number
- Medication name and dosage
- Administration route and/or other direction
- Date and times to be taken
- Licensed prescriber's name
- Pharmacy name, address, and phone number

Non-prescription medication must be brought to school in the manufacturer 's original container with the label indicating the ingredients and the student's name affixed.

Students may receive prescription and non-prescription medication at school only when the student's parent/guardian has submitted the completed School Medication Authorization Form.

For Asthma Medication
For asthma medication, the student's parent/guardian must provide the school with the prescription label containing the name of the medication, the prescribed dosage, and the times or circumstances under which the medication is to be administered.

The School Medication Authorization Form (with specific authorization for the student to self-carry) must be completed and given to the school before a student can possess medication at school.