Student Medical Authorization Form

(Attach CCUSD #139 Board Policy #7:270)

Required when a student needs to take prescription and non-prescription medication to be taken at school.

Student's Name: _____ **Birthdate:** _____

Address: _____

Home Phone: _____ **Emergency Phone:** _____

School:

Chester Grade School Grade: _____

Chester High School Grade: _____

*To be completed by the student's physician, physician's assistant, or advanced practice RN (***Note***: for asthma inhalers only, use the "Asthma Inhalers" 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? ☐ Yes ☐ No

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

_____

_____Antacid Tablets _____Benadryl _____Ibuprofen _____Tylenol

MUST HAVE PHYSICIAN'S SIGNATURE ON THIS FORM.

_____ _____

Physician's Signature **Date**

Further Instructions/Remarks:

_____

_____

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, in 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. **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): _____

Phone: _____ Emergency Phone: _____

_____

Parent/Guardian signature Date

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

I authorize Chester Community Unit School District #139 and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her 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-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).
If you agree please initial:_____

_____

Signature of Parent/Guardian

Asthma Inhalers

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