School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s).
This form is to be used for medication other than medical cannabis, (See 7:270-E2, School Medication Authorization Form-Medical Cannabis.) A new form must be completed every school year for each medication. Keep in the school nurse's office or, in the absence of the school nurse, the Building Principal's office.

Student's Name: _____Birth Date: _____
Address: _____
Home Phone: _____Cell Phone: _____Emergency Phone: _____
School: _____Grade: _____Teacher: _____

To be completed by student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:
Prescriber's Printed Name: _____
Office Address: _____
Office Phone: _____Emergency Phone: _____
Medication Name: _____
Purpose: _____
Dosage: _____Route: _____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: _____
_____

For all Parent(s)/Guardian(s) of students requiring asthma inhalers and/or epinephrine injectors:
Is the asthma inhaler and/or epinephrine injector required under a qualifying plan pursuant to 105 ILCS 5/10-22.21b, amended by P.A. 101-205, eff. 1-1-20? ☐ Yes ☐ No

Parent(s)/Guardian(s) please attach prescription label (asthma inhaler) and/or written statement (epinephrine injector) here:

For asthma inhalers, attach the prescription label with 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. 105 ILCS 5/22-30(b)(2)(i).

For an epinephrine injector, attach a written statement from the student's physician, physician assistant, or advanced practice registered nurse containing the name and purpose of the epinephrine, injector; the prescribed dosage; and the time or times at which or the special circumstances that the epinephrine injector should be administered. 105 ILCS 5/22-30(b)(2)(ii)(A)-(C).

Prescriber's Signature: _____Date: _____

For all parent(s)/guardian(s):

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 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 of has expired. 105 ILCS 5/22-30, amended by P.A.s 100-726 and 100-799; 105 ILCS 145/27, added by P.A. 101-428. **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): _____
Home Phone: _____Cell Phone: _____Emergency Phone: _____

_____ _____

Parent/Guardian Signature Date