# Students

**Exhibit – School Medication Authorization Form**

*To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office:*

| | | |
|---|---|---|
| Student's Name: | | Birth Date: |
| Address: | | |
| Home Phone: | Emergency Phone: | |
| School: | Grade: | Teacher: |

*To be completed by the student's physician:*

| | | |
|---|---|---|
| Physician's Printed Name: | | |
| Office Address: | | |
| Office Phone: | Emergency Phone: | |
| Medication: | | |
| Dosage: | Frequency: | |
| Time medication is to be administered or under what circumstances: | | |
| Prescription date: | Order date: | Discontinuation 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 | | |
| Expected side effects, if any: | | |
| Time interval for re-evaluation: | | |
| Other medications student is receiving: | | |

_____ _____

Physician's signature Date:

*By signing below, I agree:*

1. 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 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, and**

2. 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 self-administration of medication by the pupil.

| | | |
|---|---|---|
| Parent/Guardian printed name | Parent/Guardian signature* | Date |
| Parent/Guardian printed name | Parent/Guardian signature* | Date |

* both parents and/or guardians, if available, should sign.

## Students

**Request for Self-Administration of Medication – Asthma**

Name _____ Birthdate _____

Grade _____ School _____

The above name student has _____. I am requesting that the above named student take
Diagnosis/Condition
as needed the following medication during school hours.

Medication _____ Dosage _____

Frequency of use _____ Side effects _____

I certify that _____ has been instructed in the use and self-administration of
Name
_____. The above named student understands the need for the
Medication
medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I may be reached at the following phone number in the event of a reaction to the medication or an emergency:

_____ _____
Print name of Physician Physician signature Date

_____ _____
Phone Address

_____ _____
Parent signature Date Student signature Date

**WAIVER OF LIABILITY**

*For parent(s)/guardian(s) of students who have asthma:*

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

If you agree please initial: _____
Parent(s)/Guardian(s) initial

## Students

**Request for Self-Administration of Medication – Epi-Pen**

Name _____ Birthdate _____

Grade _____ School _____

The above name student has _____. I am requesting that the above named student take
Diagnosis/Condition
as needed the following medication during school hours.

Medication _____ Dosage _____

Frequency of use _____ Side effects _____

I certify that _____ has been instructed in the use and self-administration of
Name
_____. The above named student understands the need for the
Medication
medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I may be reached at the following phone number in the event of a reaction to the medication or an emergency:

_____ _____
Print name of Physician Physician signature Date

_____ _____
Phone Address

_____ _____
Parent signature Date Student signature Date

**WAIVER OF LIABILITY**

I, the parent or guardian of _____, request that the above named student carry and self-administer his/her prescribed epi-pen medication. I understand that self-administration means that the student has the discretion as to the use of his/her medication. This permission allows my child to possess and use medication without school personnel supervision while in school, while at a school-sponsored activity and during, before or after normal school activities, such as before or after-school care on school-operated property.

I also understand that the district or school along with its employees andagents, incur no liability as a result of any injury arising from my child's self-administration of theepi-pen medication. I agree to hold harmless the District or school, along with its agents and employees, against any claims.

If you agree please initial: _____
Parent(s)/Guardian(s) initial

## Students

**Request for Self-Administration of Medication – Insulin**

Name _____ Birthdate _____

Grade _____ School _____

The above name student has _____. I am requesting that the above named student take
Diagnosis/Condition
as needed the following medication during school hours.

Medication _____ Dosage _____

Frequency of use _____ Side effects _____

I certify that _____ has been instructed in the use and self-administration of
Name
_____. The above named student understands the need for the
Medication
medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently. I may be reached at the following phone number in the event of a reaction to the medication or an emergency:

_____ _____
Print name of Physician Physician signature Date

_____ _____
Phone Address

_____ _____
Parent signature Date Student signature Date

**WAIVER OF LIABILITY**

I, the parent or guardian of _____, request that the above named student carry and self-administer his/her prescribed diabetic medication. I understand that self-administration means that the student has the discretion as to the use of his/her medication. This permission allows my child to possess and use medication without school personnel supervision while in school, while at a school-sponsored activity and during, before or after normal school activities, such as before or after-school care on school-operated property.

I also understand that the district or school along with its employees and agents, incur no liability as a result of any injury arising from my child's self-administration of the diabetic medication. I agree to hold harmless the District or school, along with its agents and employees, against any claims.

If you agree please initial: _____
Parent(s)/Guardian(s) initial