

# PENNOYER SCHOOL DISTRICT 79

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## SCHOOL MEDICATION AUTHORIZATION FORM

*To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.*

### PLEASE PRINT

STUDENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_

*To be completed by the student's physician, physician assistant, or advanced practice RN (Note: for asthma inhalers only, use the "Asthma Inhalers" section on back):*

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: \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

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## ASTHMA INHALERS

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

### FOR ONLY PARENTS/GUARDIANS OF STUDENTS WHO NEED TO CARRY ASTHMA MEDICATION OR AN EPINEPHRINE AUTO-INJECTOR:

I authorize the School District 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: \_\_\_\_\_  
Parent/Guardian

### 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 above): \_\_\_\_\_

Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

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