RIVER FOREST PUBLIC SCHOOLS – www.district90.org
Administration Building - 7776 Lake Street, River Forest, IL 60305 - 708-771-8282 /Fax 708-771-8291

SCHOOL MEDICATION AUTHORIZATION FORM for 2024-2025 school year

Student Name: _______________________________________________ Birthdate __________ Age ______ Sex ______

School __________________________ Grade Level __________

PHYSICIAN'S ORDER: (needed for prescription and/or over-the-counter medicine)

Medication #1 _____________________________________________ Dosage __________________

Time to be given/Instructions ___________________ Route __________ Starting Date __________

Diagnosis/Reason for medication ____________________________________________________________

Procedure if dosage is missed _____________________________________________________________

Possible side-effects ____________________________________________________________

Medication #2 _____________________________________________ Dosage __________________

Time to be given/Instructions ___________________ Route __________ Starting Date __________

Diagnosis/Reason for medication __________________________________________________________

Procedure if dosage is missed ___________________________________________________________

Possible side-effects _______________________________________________________

Other Medications student is receiving ______________________________________________________

<table>
<thead>
<tr>
<th>Asthma or Allergy Medication Only:</th>
<th>☐ ASTHMA Inhaler</th>
<th>☐ Epi-Pen</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>Student may carry medication on his/her person</td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td>Student may self-administer medication. Directions for self-administration:</td>
<td></td>
</tr>
</tbody>
</table>

Physician's Name (Print) __________________________________________ Address or Office Stamp:

Physician's Signature ____________________________________________

Date __________________________ Phone _______________________

PARENT/LEGAL GUARDIAN AUTHORIZATION:

I give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by a pharmacy. If it is over-the-counter, it will be sent in the original package with my child's name on it. I will notify the school in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication order is changed.

Parent/Guardian Name (Print) __________________________________________

Parent/Guardian Signature ___________________________________________ Date __________

Daytime contact numbers: Cell___________________ Work_________________ Home ______________

OVER >>> for Parent/Guardian Agreement Authorizing Self-Administration of Asthma Medication or Epi-Pen

--- Additional Parent/Guardian Signature required on back ---

OVER >>>
Agreement Authorizing Self-Administration of Asthma Medication or Epi-Pen

I/We, ________________________________, the parent(s) or legal guardian(s) of ________________________________, a student at River Forest School District 90, hereby authorize my/our child to self-administer:

_____ Asthma Medication
_____ Epi-Pen

while at school and have provided a physician's statement in compliance with State statute. I/We have instructed my/our child not to share his/her medication with any other student. Additionally, I/We understand that according to State statute, the School District and its employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of the:

_____ Asthma Medication
_____ Epi-Pen

by my/our child. I/We further understand and agree that as the parent(s) or legal guardian(s) of my/our child, I/we must 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:

_____ Asthma Medication
_____ Epi-Pen

by my/our child. I/We further understand that this permission for self-administration of:

_____ Asthma Medication
_____ Epi-Pen

is effective for this school year only, and must be renewed each subsequent school year, if desired. I/We understand that a copy of this permission will be kept in my/our child's medical file.

Parent/Guardian Name (Print) ________________________________

Parent/Guardian Signature _______________________________ Date _________________

Daytime contact numbers:
Cell ________________ Work ________________ Home ________________

Revised 2/2024