Illini Central District #189
Medication Authorization Form

(to be completed annually)

To be completed by student's parent/guardian and kept in the nurse's office

Student's Name:_____ Birth date:_____

Address:_____

Phone:_____Emergency contact name:_____

School:_____Grade/Teacher_____

Medication Allergies:_____

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 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 be performed by an individual other than a school nurse and specifically consent to such practices.

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

Time medication is to be given: at school_____

at home_____

For parents/guardians of Middle/High School 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 asthma medication. 1) while in school 2) while at a school sponsored activity 3) while under the supervision of school personnel 4) before or after normal school activities, such as before or after school care on the school-operated property. Illinois law requires the school district to inform parents/guardians 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.

If you agree, please sign:_____
Parent/Guardian Signature

To be completed by the student's physician for all medication:

Phyiscian's printed name:
Office address: City, State
Office phone:
Medication:
Dosage: Frequency:
Prescription date: Order date:
Diagnosis requiring medication:
Intended effect of this medication:
For asthma: May this student self-administer this medication (Middle School/High School only) _____ yes _____no
Expected side effects, if any:
Time interval for re-evaluation:
Other medication this student is taking: