District 87/Unit 5
Medication Authorization Form

Name: _____ Date of Birth: _____
(Last, First, Middle Initial)

As the parent/guardian, I understand that it is the policy of the district that as a regular and normal practice, medication should not be administered to a student at school or when such student is involved in school activities. However, in order to provide for the critical health and well-being of students, under exceptional circumstances, medication may be administered during school hours by a certified school nurse, a registered nurse, administrative personnel, administrative designee, or self-administered by a student. I further release my child's school district, its Board of Education, and individual members thereof, and its employees shall be indemnified and held harmless from any and all claims arising out of the administration of said medication.

Medication must be brought to the school in a container, labeled appropriately by the pharmacist or licensed prescriber.

I request that my child be assisted in taking the medications(s) described below at school by authorized persons or be permitted to medicate herself/himself as also authorized by me and my physician (see below). I further consent to the sharing of relevant medical information between the school and the physician's office.

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

For parent(s)/guardian(s) of students who need to carry asthma medication or an EpiPen:
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 and/or epinephrine auto-injector while in school, at a school-sponsored activity, under the supervision of school personnel, or 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: _____

PRINTED PHYSICIAN'S NAME:	
PHYSICIAN'S ADDRESS:	**PHONE:**
Medication:	
Purpose of Medication/Diagnosis:	
Form: (i.e. tab, injection, etc.)	
Dose:	
Time of Administration:	
If medicine to be given "when needed." Describe indications:	
How soon can it be repeated?	
Is child authorized to medicate herself/himself?	
List significant side effects:	
Length of time this treatment is recommended:	
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 that may arise at school?	Yes No

_____ _____ _____
Date Physician's Signature **Only** Physician's Telephone

Nurse's Initials_____