Arthur Community Unit School District #305

School Medication Authorization Form

No medication will be administered until this form is completed and returned to the school office. All medication must be furnished by the parent and brought to the school office. The container should be appropriately labeled by a pharmacy or an original bottle with the student's name on the bottle. All medication is kept in a safe that has a limited space, please send small bottles.

Aspirin, Tylenol, cold tablets, cough medicine or any otherwill not be administered by personnel unless this formis on file. Parents are welcome to come to school any time for the administration of medicine.

To be completed by the students Parent(s)/Guardian(s). A new form must be completed every school year.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____Emergency Phone: _____

School: _____Grade:_____Teacher:_____

To be completed by the student's Physician, Physician Assistant, or Advanced Practice Nurse:

Physician's Printed Name: _____

Office Address: _____Office Phone: _____

Medication Name: _____ Dosage: _____

Frequency: _____Purpose:_____

Time medication is to be administered or under what circumstance: _____

Prescription date: _____ Order date: _____ Discontinued date: _____

Diagnosis requiring medication: _____

Expected side effects, if any: _____

_____ _____

Physician's Signature: **Date:**

Parents/Guardians please sign the back of this form

For only Parents/Guardians 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: (1) while in school, (2) while at 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 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: _____

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 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 that a school health aide 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:	**Parent/Guardian Signature:**	**Date:**