HENRY-SENACHWINE CUSD5 MEDICATION AUTHORIZATION FORM

This form is to be completed by the student's parent(s)/guardian(s) and kept in the school nurse's office or in the absence of a school nurse, in the Building Principal's office.

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|---|---|
| Student's Name: | Birthdate: |
| Address: | |
| Home/Cell Phone: | Work Phone: |
| School: Henry-Senachwine Grade & JH School | Grade/Teacher: |
| Medication: | |
| Dosage: | Frequency: |

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN (FOR PRESCRIPTION DRUGS ONLY):

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|---|---|
| Physician's Printed Name: | |
| Office Address: | |
| Office Phone: | Emergency Phone: |
| Medication: | |
| Dosage: | Frequency: |
| Time medication to be administered or under what circumstances: | |
| Prescription Date: | Order Date: |
| Discontinuation Date: | Diagnosis requiring medication: |
| Intended effect of this medication: | Expected side effects if any: |
| Does this medication need to be administered during the school day in order to allow the child to attend school or to address the student's medical condition? YES NO | |
| Time interval for reevaluation: | Other medications students is receiving: |
| PHYSICIAN'S SIGNATURE | DATE: |

**PLEASE SEE BACK SIDE**

**FOR PARENT(S)/GUARDIAN(S) OF 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 or her asthma medication (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, expect 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:** _____

Parent(s)/Guardian(s) Initials

**BY SIGNING BELOW I AGREE:**

**I.** 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 to 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 medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and**

**II.** 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 Printed Name

_____ _____

*Parent/Guardian Signature/Date *Parent/Guardian Signature/Date

*Both parents and/or guardians, if available, should sign.