School District 45, DuPage County
255 W. Vermont St
Villa Park, IL 60181
Phone (630) 516-770

SCHOOL MEDICATION AUTHORIZATION FORM

This authorization is good only for the current school year. Medication must be brought to school by an adult and given to an adult at the school. A receipt of medication form needs to be signed in the school health office when dropping off medication. The medication must be in its original container provided by the pharmacy with the pharmacy label in place. Any changes in medication or dosage require that a new form be completed.

STUDENT NAME_____BIRTHDATE _____

ADDRESS_____PHONE NUMBER_____

SCHOOL_____GRADE _____

EMERGENCY CONTACT NAME & NUMBER_____

I. TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER

Only medications which are prescribed by a physician and which are essential for the student to remain in school shall be given.

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered:

_____

Side Effects: _____

Special Instructions: _____

Date of Prescription: _____

May this student self-carry/self-administer (asthma medication only): YES NO

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____	_____	_____
Phone Number of Physician	Signature of Physician	Date
_____	_____	_____
Address of Physician	Print Name of Physician	Date

II. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

(over)

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____

Self-Administration of Asthma Medication: _____Yes _____No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified healthcare professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school with an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Signature: _____ Date: _____

III. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I, _____, parent or guardian of _____, am primarily responsible for administering medication to my child. However, **in a medical emergency or if necessary for the critical health and well-being of my child**, I hereby authorize School District No. 45 (the "District"), and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than a nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this **medication authorization is only effective for the current school year and will need to be renewed each subsequent school year**.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the District, its employees and agents, arising out of the administration or self-administration, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Signature: _____ Date: _____

***Unused medication will not be sent home with the child and needs to be picked up on the last day of school by an adult. Medication will be destroyed if not picked up by the last day of school.**