Saratoga Community Consolidated School District 60C

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SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME____ BIRTH DATE_______________________________

ADDRESS____ PHONE NUMBER____________________________

SCHOOL___________________________ GRADE______________ TEACHER___________________________________

THE STUDENT'S PHYSICIAN SHOULD COMPLETE THE INFORMATION BELOW. A NEW FORM MUST BE COMPLETED EVERY SCHOOL YEAR

NAME OF MEDICATION____

DOSAGE______________________________ FREQUENCY_________________________TIME TO BE GIVEN IN SCHOOL_________

PRESCRIPTION DATE__________________ ORDER DATE________________________ DISCONTINUATION DATE_____________

DIAGNOSIS REQUIRING THIS MEDICATION____

IS IT NECESSARY FOR THIS MEDICATION TO BE ADMINISTERED DURING THE SCHOOL DAY?_____________________________

EXPECTED SIDE EFFECTS, IF ANY____

TIME INTERVAL FOR RE-EVALUATION____

OTHER MEDICATIONS STUDENT IS RECEIVING____

__________________________________ __________________________________

PHYSICIANS NAME – PRINT   PHYSICIANS NAME – SIGNATURE

OFFICE ADDRESS AND PHONE NUMBER

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 it's employees and agents, in my behalf, 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 medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and it's 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 printed name

______________________________ ______________________________

Parent/Guardian signature   Date   Parent/Guardian signature   Date

ONLY FOR PARENTS/GUARDIANS OF STUDENTS WHO NEED TO CARRY ASTHMA MEDICATION OR AN EPIPEN:
I authorize the School District and it's 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 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 that it, and it's employees and agents, incur no liability, except for the 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:*________________________________

Parent(s)/guardian(s)