

PRINCETON ELEMENTARY SCHOOL DISTRICT #115
SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ HOME PHONE _____

SCHOOL _____ GRADE _____ EMERGENCY PHONE _____

To be completed by the student's physician or physician's designee

NAME OF MEDICATION _____ DOSAGE _____

FREQUENCY _____ TIME TO BE GIVEN IN SCHOOL _____

DATE OF PRESCRIPTION _____ DATE OF ORDER _____ DISCONTINUATION DATE _____

1. DIAGNOSIS REQUIRING MEDICATION _____ RE-EVALUATION DATE _____

2. POSSIBLE SIDE EFFECTS _____

3. OTHER MEDICATIONS THE STUDENT IS RECEIVING _____

4. 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? _____

5. MAY STUDENT SELF-ADMINISTER THIS MEDICATION **WITH DIRECT ADULT SUPERVISION**? _____

6. IS THIS STUDENT AWARE OF SIDE EFFECTS AND ABLE TO CARRY AND USE THIS MEDICATION INDEPENDENTLY (i.e. inhalers for students grade 5 and above)? _____

7. FURTHER INSTRUCTIONS/REMARKS _____

Physician's Name—Print Physician's Signature Date

Address Phone—Office Phone—Emergency

FOR ALL PARENTS/GUARDIANS—(both parents/guardians, if available, need to read and sign)

I agree that I am primarily responsible for administering medication to my child. However, if I am unable to do so or in the event of a medical emergency, I authorize Princeton Elementary School Dist. 115 and its employees and agents to administer, attempt to administer, or allow my child to self-administer (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 or supervision of medication to my child be performed by an individual other than a school nurse, and specifically consent to such practices. I agree to hold harmless and indemnify the school district and its employees and agents against any claims arising out of administration of medication, attempts to administer medication, or supervision of the child's self-administration of medication..

Parent/Guardian—Print Name Parent/Guardian—Print Name

Parent/Guardian Signature Date Parent/Guardian Signature Date

FOR PARENTS/GUARDIANS OF STUDENTS WHO NEED TO CARRY MEDICATION (i.e. asthma medication, EpiPen)
I authorize Princeton Elementary School Dist. 115 to allow my child to possess and use asthma medication and/or epinephrine auto-injector: while in school, while at a school-sponsored activity, while under the supervision of school personnel, and before or after normal school activities. Illinois law requires the school district to inform parents/guardians that it and its employees and agents incur no liability as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

Parent Signature Date