SR 20

School District #117
Jacksonville, IL 62650
SCHOOL MEDICATION/TREATMENT AUTHORIZATION FORM

Student's Name_____ Birthdate_____School_____

Address _____ Grade/Teacher_____

Home Phone _____ Emergency Phone _____

To be completed by student's physician, physician assistant, or advanced practice RN:

Name of Medication _____ Dosage _____

Is it necessary for this medication to be administered during the school day? ☐ Yes ☐ No

Time(s) _____ Duration of administration _____

Type of illness or disease _____

Side effects to be alerted to: _____

List of other medications he/she receives:_____

Additional remarks: _____

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

_____

Physician's signature Date

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 to 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:_____***

Parent(s)/guardian(s)

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize School Dist. #117 and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child or allow my child to self-administer, if physician approved. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the medication is to administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, it's employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries and/or death incurred or resulting from the administration or attempts to at administration of said medication. I recognize that I am responsible at the end of treatment period for removing from the school any unused medication that was authorized for my child. If I do not pick up the medication by the end of the school year, the principal will dispose of it.

_____ _____

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.*

*If physician and parent approval given, student may self-administer non-oral medication.

Principal_____ School Nurse_____