Crystal Lake School District 47
MEDICATION AUTHORIZATION FORM
A new form **must** be completed every school year.

Student's Name_____ Birth date_____

Address: _____

Home Phone: _____Cell Phone: _____Emergency Phone: _____

School: _____ Grade_____ Teacher: _____

PHYSICIAN AUTHORIZATION
To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority (Note: for asthma inhalers only, use the Asthma Inhalers section below):
Prescriber's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

Prescription date:_____Order date: _____Discontinuation date:_____

Diagnosis requiring medication: _____

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

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Known allergies_____

Other medications student is receiving: _____

_____ _____
Prescriber's Signature Date

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Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label here:

PARENT/GUARDIAN AUTHORIZATION FOR STUDENT TO SELF-ADMINISTER MEDICATION

For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine 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 schooloperated 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-carry and self-administration of asthma medication or epinephrine injector. 105 ILCS 5/22-30, amended by P.A.s 100-726 and 100-799, eff. 1-1-19.

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

_____
Parent/Guardian Initials

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 its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-726 and 100-799, eff. 1-1-19. **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 its 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 Signature_____ Date_____

Address (if different from Student's above): _____

Home Phone: _____Cell Phone: _____Emergency Phone: _____

_____ _____
Parent/Guardian Signature **Date**

Revised 11/19/2018