School Medication Authorization Form

To be completed by the student's parent/guardian AND PHYSICIAN and kept in the school office.

Student's Name:		Birth Date:
Address:		
Mother/Parent #1 Name:	Phone #:	
Father/Parent #2 Name:	Phone #:	
Class:	Grade:	Age:

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Physician's printed name:	
Office Address:	Office Phone: Office Fax:
Medication:	Exp. Date:
Dosage:	Frequency:
Time medication is to be administered or under what circumstances:	
Diagnosis requiring medication:	
Intended effect of this medication:	
Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition?	❑ **Yes** ❑ No
Expected side effects if any:	
Time interval for re-evaluation:	
Has student been taught to self administer this medication?	❑ Yes ❑ No
Does student have your approval to administer this medication?	❑ Yes ❑ No
Other medication student is receiving:	

Physician's Signature Date

AFFIX PRESCRIPTION LABEL HERE:

COMPLETE BOTH SIDES PARENT SIGNATURE REQUIRED

By signing below, I agree:

1. 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 Quentin Road Christian and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of Quentin Road Christian), 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

2. To indemnify and hold harmless Quentin Road Christian and its employees and agents any claims, except a claimbased on willful and wanton conduct arising out of the self-administration of medication by the student.

_____ ★ _____

Parent/Guardian printed name Parent/Guardian signature

FOR PARENTS OF STUDENTS WHO SELF ADMINISTER MEDICATIONS

I authorize Quentin Road Christian and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, diabetic supplies or "Epi-Pen" (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.
I verify that my child has been instructed and can self-administer his/her prescribed medication in accordance with the prescribed dosage and route. Also my child is aware of potential side effects, when medication is not effective, and when additional help is needed. Illinois law requires the School District to inform parents(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 (105 ILCS 5/22-30).

If you agree, please initial: _____

Parent/Guardian initial

For Office Use only

Admin by:	Date/Time:	Admin by:	Date/Time:	Admin by:	Date/Time:

School staff must sign/date when administered