SOUTH CENTRAL COMMUNITY SCHOOL

District Number #401
Nurse's office
810 East First Street
Kinmundy, Illinois 62854
618-547-7696
Fax: 618-547-3144

SCHOOL MEDICATION AUTHORIZATION FORM

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: South Central School District #401 Grade: ___ Teacher: _____

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

Physician'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: _____Discontinued date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? Y N
Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications the student is receiving: _____

_____
Physician's Signature Date

For only parents/guardians of students who need to carry asthma medication or an EpiPen:

I authorize the South Central 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 a school sponsored activity, (3) while under the supervision of school personnel, or (4) before-school or after-school care on school-operated property. Illinois law requires the South Central School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, expect for willful and wanton

conduct, as a result of any injury arising form 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)

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 South Central School District and its 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 manner described above. **I acknowledge that it may be necessary for the administration of medication 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 South Central School District and its employees and agent against any claims, except a claim based on willful and want to 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

* Both parents and/or guardians, if available, should sign.