Edwards County Community Unit School District #1

School Medication Authorization Form

This form is not for use with an Asthma Inhaler, epinephrine auto-injector, or Medical Cannabis; see specific forms for these medications.

A new form must be completed every school year or for dosage/frequency changes. Medication & Authorization forms should be kept in the nurse's office, or in the absence of a school nurse, the Building Principal's office.

Section to be completed by child's parent/guardian: (also complete bottom of page)

Student's Name: _____ Date of Birth: _____ Grade: ____ School: _____

Parent/Guardian Name: _____Phone: _____ Teacher: _____

Section to be completed & signed by child's physician, physician assistant, or advanced practice RN:

Medication #1: _____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Dose: _____ Frequency: _____

Time to administer: _____ Purpose: _____

Diagnosis requiring medication: _____

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

Expected side effects: _____ Time interval for re-eval: _____

Other medications student is receiving: _____

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Medication #2: _____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Dose: _____ Frequency: _____

Time to administer: _____ Purpose: _____

Diagnosis requiring medication: _____

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

Expected side effects: _____ Time interval for re-eval: _____

Other medications student is receiving: _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

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 agent 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 100-799 eff. 1-1-19. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the 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_____ **Home/Cell Phone:** _____

Parent/Guardian Signature_____ **Date:** _____

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