Lincoln-Way Area Special Education
Joint Agreement District #843

601 Willow Street ● Frankfort, IL 60423 ● Phone: (815)806-4600 ● Fax: (815)806-4601

SCHOOL MEDICATION AUTHORIZATION FORM

Student's Name _____ Birth Date _____

Address _____ Phone Number _____

School/Teacher _____ Grade _____

Emergency Contact Name & Phone Number _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN:

I, _____, parent or guardian of _____, am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Lincoln-Way Area Special Education Joint Agreement District 843, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of District 843, lawfully prescribed medication in the manner described on page 2. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Lincoln-Way Area Special Education Joint Agreement District 843, and its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse. In addition, I agree to indemnify and hold harmless Lincoln-Way Area Special Education Joint Agreement District 843, and its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

SCHOOL MEDICATION AUTHORIZATION FORM
ONE (1) FORM PER STUDENT PER MEDICATION IF APPLICABLE

Student's Name _____ Birth Date _____

II. TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER:
(Except for a Student Self-Administering Asthma Medication, see Student Self-Administering Asthma Medication Form)

Diagnosis: _____ Name of Medication: _____

Dosage: _____

Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

_____

Frequency: _____

Side Effects: _____

_____

_____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Epinephrine: ☐ Yes ☐ No The student listed on page 1 has a life threatening allergy that medically necessitates the administration of Epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of doing this independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: ☐ Yes ☐ No The student listed on page 1 has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____ _____
Phone Number of Physician | Signature of Physician | Date

_____ _____
Address of Physician | Print Name of Physician