Lincoln-Way Area Special Education
Joint Agreement District 843

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School Medication Authorization Form
(for Student Self-Administering Asthma Medication only)

Student's Name _____ Birth Date _____

Address _____ Phone Number _____

School/Teacher _____ Grade _____

Emergency Contact Name and 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

ASTHMA MEDICATION AUTHORIZATION FORM

II. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____

Route of Administration: _____

Time/Circumstances when Medication Should be Administered:

_____

_____

Side Effects:

_____

_____

_____

_____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: ☐ Yes ☐ No My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date