Peotone School District 207-U

Medication Authorization Form (Rev 3/22)

This order is valid only for the current school year_____(Including Summer Session) OR

Start Date:_____ to Stop Date_____

This medication form must be completed fully and signed by parent **AND** physician in order for staff to administer any medication. A new medication authorization form must be completed at the beginning of each school year and each time there is a change in dosage, or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or provider
- Over-the-counter medication must be in the original unopened container with label intact
- Students are prohibited from transporting medications
- The provider will be called if a question arises about a student and their medication
- If the child has diabetes, parents should contact the school nurse to discuss a Diabetes Care Plan.

Student Name_____Grade_____Birth Date_____Home Phone_____

To be completed by student's physician:

Peotone School District maintains a stock of the following generic medications. I authorize the District to administer:
(Please check all that apply)

☐Acetaminophen Dose:_____Frequency:_____Indication:_____

☐Ibuprofen Dose:_____Frequency:_____Indication:_____

☐Benadryl Dose:_____Frequency:_____Indication:_____

☐Triple antibiotic ointment ☐Hydrocortisone cream ☐Eye drops ☐Sting relief ☐Caladryl ☐Burn gel ☐Tums

Other medication: (Inhaler, nebulizer, epi-pen, etc.)

Name_____Dosage_____Frequency_____

Diagnosis requiring medication_____

Possible side effects_____

Conditions under which medications should be administered, including directions for administration by school personnel, and any additional instructions_____

_____

_____

Other medications the student is receiving_____

_____

If this prescription is for an inhaler or epinephrine auto-injector, should the student carry the inhaler or auto-injector on his/her person? Yes_____ No_____

_____ _____ _____

Physician's Signature **Physician's Name** **Date**

_____ _____

Phone Number **Fax Number**

Use for Health care Provider's Address Stamp:

PLEASE READ THIS DOCUMENT CAREFULLY AS YOU ARE WAIVING CERTAIN LEGAL RIGHTS YOU MAY OTHERWISE HAVE

RELEASE AND HOLD HARMLESS FOR MEDICATIONS

To be completed by Parent or Guardian:

I hereby confirm that I am primarily responsible for administering medication to my child. However, in the event of a medical emergency, or if necessary, for the critical health and well-being of my child, I hereby authorize the **PEOTONE SCHOOL DISTRICT** and its employees and agents, on my behalf and stead, to administer or to attempt to administer medication to my child during school hours or while under the supervision of school personnel.

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.

I understand that my child is expected to be compliant in the medication treatment plan as ordered by the physician. I further acknowledge and agree that, when lawfully prescribed medication(s) is so administered or attempted to be administered or is self-administered by my child, to the fullest extent permitted by law I waive any claims I might have against the School District, release and hold the District, its employees and agents either jointly or severally, harmless from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

I further represent to the School District that my child ___is ___is not (check one) capable of self-administering the medication.

I authorize the school nurse to talk with the prescribing physician by phone about the medication if needed.

_____ ___	_____	_____ _____	_____
Parent Name	Phone Number	Parent Signature	Date

For parent(s)/guardian(s) of students with physician permission to carry epinephrine auto-injectors and/or inhalers:

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her epinephirne auto-injector and/or asthma medication (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. Illinois law requires the School District to inform parent(s)/ guardian(s) that it, and its employees and agents, incur no liability, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree please sign: _____

Parent/Guardian Signature