# La Moille C.U.S.D. #303 School Medication Authorization Form

***To be completed by the child's parent(s)/guardian(s).***
***This form is to be used for medication other than medical cannabis. (See 7:270-E2, School Medication Authorization Form - Medical Cannabis.) A new form must be completed every school year for each medication. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.***

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| **Student's Name:** | | | | **Birth Date:** | |
| **Address:** | | | | | |
| **Home Phone:** | | **Cell Phone:** | | **Emergency Phone:** | |
| **School:** | | **Grade:** | | **Teacher:** | |

*To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:*

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| **Prescriber'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:** | | **Discontinuation date:** | |
| **Diagnosis requiring medication:** | | | | | |
| **Is it necessary for this medication to be administered during the school day?** | | | ☐ **Yes** ☐ **No** | | |
| **Expected side effects, if any:** | | | | | |
| **Time interval for re-evaluation:** | | | | | |
| **Other medications student is receiving:** | | | | | |
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| | | | | | |
| **Prescriber's Signature** | | | | **Date** | |

*For only Parent(s)/Guardian(s) of students requiring asthma inhalers and/or epinephrine injectors:*
**Is the asthma inhaler and/or epinephrine injector required under a qualifying plan pursuant to 105 ILCS 5/10-22.21b, amended by P.A. 101-205, eff. 1-1-20?**
☐ **Yes** ☐ **No**

*Parent(s)/Guardian(s) please attach prescription label (asthma inhaler) and/or written statement (epinephrine injector) here:*

***For asthma inhalers, attach the prescription label with the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered. 105 ILCS 5/22-30(b)(2)(i).***
***For an epinephrine injector, attach a written statement from the student's physician, physician assistant, or advanced practice registered nurse containing the name and purpose of the epinephrine, injector; the prescribed dosage; and the time or times at which or the special circumstances that the epinephrine injector should be administered. 105 ILCS 5/22-30(b)(2)(ii)(A)-(C).***

***For only parents/guardians of students who need to self-administer medication required under a qualifying plan:***
**I grant permission for my child to self-administer his or her medication required under an asthma action plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization Form, a plan pursuant to Section 504 of the federal Rehabilitation Act of 1973, or a plan pursuant to the federal Individuals with Disabilities Education Act. 105 ILCS 5/10-22.21b, amended by P.A. 101-205, eff. 1-1-20.**

Medication(s) other than asthma inhalers and/or epinephrine injectors (complete section above) required under a qualifying plan that student is permitted to self-administer:

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| **Prescription date:** | | **Order date:** | | **Discontinuation date:** | |
| **Diagnosis requiring medication:** | | | | | |
| **Is it necessary for this medication to be administered during the school day?** | | | | ☐ **Yes** ☐ **No** | |
| **Expected side effects, if any:** | | | | | |
| **Time interval for re-evaluation:** | | | | | |
| **Other medications student is receiving :** | | | | | |
| | | | | | |
| **Prescriber's Signature** | | | | **Date** | |

**If the medication is an asthma inhaler or epinephrine injector, be also sure to complete the section above and attach the required label and/or written statement as required above.**

*Please initial to indicate (1) receipt of this information, and (2) authorization for your child to self-administer medication under a qualifying plan.*

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**Parent/Guardian Initials**

***For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:***

**I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine injector: (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, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine injector. 105 ILCS 5/22-30, amended by P.A.s 100-726 and 100-799, eff. 1-1-19.**

*Please initial to indicate (1) receipt of this information, and (2) authorization for your child to carry and use his or her asthma medication or epinephrine injector.*

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**Parent/Guardian Initials**

*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 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 agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication to my child when there is a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on-site of has expired. 105 ILCS 5/22-30, amended by P.A.s 100-726 and 100-799; 105 ILCS 145/27, added by P.A. 101-428.** 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**, 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.

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Parent/Guardian Printed Name

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| **Address (if different from Student's above):** | | | | | |
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| **Home Phone:** | | **Cell Phone:** | | **Emergency Phone:** | |

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Parent/Guardian Signature Date