MEDICATION AUTHORIZATION FORM

To be filed at the student's school building

Student's Name: DOB:

Address:

Home Phone: Emergency Phone:

School: Grade: Teacher:

To be completed by the student's physician:

Name of Medication: Dosage: Frequency:

Time to be given at school: Date of prescription: Date of order: Discontinuation date:

Diagnosis requiring medication: Intended effect of medication:

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition: Yes: No: Expected side effects, if any:

☐ The medication above is to be self-administered. I certify that the student named above has been instructed in the use and self-administration of the above named medication and the child can fulfill the requirements of the procedure.

☐ The above student may carry the prescribed medication and / or inhaler.

Other medications student is receiving:

Physician's Signature : Date: Physician's Name: (please print)

Physician's address: Phone: Emergency Phone:

I confirm that I am primarily responsible for the administering of 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 Alton Community Unit School District #11 and its employee's and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employee's and agents of the School District) lawfully prescribed medication in the manner described above. 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. The School Nurse caring for my child may communicate with the prescribed physician regarding medications or health issues relating to this medication. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, it's employee's and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, it's employee's and agents, either jointly or separately, 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.

☐ If your child has asthma, I understand, in accordance with the new Asthma Action Plan Law, an Asthma Action Plan MUST be provided to the school for all student's with Asthma. Please request an Asthma Action Plan from your doctor. The inhaler should be brought to school with the Asthma Action Plan and the medication authorization form and given to the nurse for review.

Parent(s) / Guardian (s) Name (Please Print)

Parent(s) / Guardian(s) Signature

Date