STUDENT MEDICAL AUTHORIZATION FORM

This form is required when a student needs to take prescription medication at school and in order for school personnel to administer the required medication. A new form must be completed for each medication every school year and with any change in the dosage of the medication. This form is filed at the Front Desk. (*Note: This form should accompany a medical action plan based on the student's specific needs.)*

Student's Name: Birth Date:

Address:

Home 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. (Also, see page 2.)

Physician'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:

Physician's signature: Date:

For only Parents/Guardians of Students with Asthma Inhalers/Epinephrine Injectors/Insulin/Other Prescribed Medications

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? _____Yes _____No

Please attach prescription label or a written statement by your medical professional here:

I authorize Everest Academy of Lemont, Inc. and its employees and agents, to allow my child or ward to **_____carry and _____self-administer** his or her **asthma inhaler/epinephrine auto-injector/insulin/other prescribed medication that is under a qualifying medical plan:** (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 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-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

Please initial below to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication, epinephrine auto-injector, **insulin, and other prescribed medication.**

_____
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, in 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. **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 Everest Academy 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.

Parent/Guardian printed name: _____

Address (if different from Student's): _____

Phone: _____ Emergency Phone: _____

_____

Parent/Guardian signature: _____ Date: _____