

CHARLESTON COMMUNITY UNIT SCHOOL DISTRICT NO. 1

School Health Office

Phone: 217-639-5015 Fax: 217-639-5018

SCHOOL MEDICATION AUTHORIZATION FORM*A new form must be completed every school year. Keep in the School Nurse's Office or in the Building Principal's Office.*

STUDENT'S NAME _____

SCHOOL _____

BIRTHDATE _____ Grade _____

The medication identified on this form must be brought in a container appropriately labeled by the pharmacy or physician. Sample medications or over the counter medications may be labeled by the parent. The container must duplicate the directions given on this request. *For asthma inhalers or epinephrine auto-injectors, attach prescription label here.*

TO BE COMPLETED (IN FULL) BY PHYSICIAN/PHYSICIAN ASSISTANT/ADVANCED PRACTICE REGISTERED NURSE. FOR ASTHMA INHALERS OR EPINEPHRINE AUTO-INJECTOR USE, A PARENT MAY COMPLETE THIS PORTION.

Name of medication to be given: _____

Purpose of medication: _____

Frequency: _____ Prescribed dosage to be given at school: _____

Time(s) or circumstance(s) medication is to be administered: _____

Diagnosis requiring medication: _____

Side effects of the medication, if any: _____

Other medications student is receiving: _____

Can the student carry and use his/her inhaler or auto-injector on him/herself? Yes No_____
Medical professional's signature & date_____
Medical professional's printed name & phone number_____
Printed name of emergency contact for student_____
Emergency contact number for student**Emergency Action Plan completed (if required):** Yes No

Asthma Severe allergy Seizures Diabetes Other: _____
(circle one)

For Parents/ Guardians of students who need to carry asthma medication or an epinephrine auto-injector (Epipen):

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under 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. By signing below, I acknowledge that the school district is to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the pupil regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse, and that I 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 self-administration of medication or use of an epinephrine auto-injector by the pupil.

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 attempt to administer to my child (or allow my child to self-administer, 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 be performed by an individual other than a School Nurse and specifically consent to such practices.

Parent/Guardian printed name_____
Parent/Guardian signature_____
Date