Laraway School District 70-C Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year.

Student's Name:_____Date of Birth:_____
Home Phone:_____Emergency Phone:_____
School:_____Grade:_____Teacher:_____

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

Physician's printed name:_____
Office Address:_____
Office Phone:_____Office Fax:_____
Medication Name:_____
Purpose:_____
Dosage:_____Route:_____Frequency:_____
Time medication is to be administered or under what circumstances:

_____
Diagnosis requiring medication:_____
Expected side effects, if any:_____
Order Date:_____Discontinuation Date:_____
Other medications student is receiving:_____

Is student authorized to carry and use his/her inhaler or Epi-pen auto-injector on him/herself? ____ Yes ____ No

Has student been instructed on the use of asthma inhaler and or Epi-pen? _____Yes _____ No

_____
Physician's signature Date

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

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