

**Exhibit - Student Medical Authorization Form**<sup>1, 2</sup>

(Required when a student needs to take prescription and non-prescription medication to be taken at school.)

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

*To be completed by the student's physician, physician assistant, or advanced practice RN (Note: for asthma inhalers only, use the "Asthma Inhalers" section below):*

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

**Asthma Inhalers**

*Parent(s)/Guardian(s) please attach prescription label here:*

<sup>1</sup> This exhibit may be placed in the handbook or given to parents/guardians as needed.

<sup>2</sup> Students who are diabetic may also self-carry and self-administer diabetic testing supplies and insulin. Diabetic students must have a separate Diabetes Care Plan. For further information, see: [www.iasb.com/law/diabmats.cfm](http://www.iasb.com/law/diabmats.cfm), Handbook Procedure 1.130 (Care of Students with Diabetes) and Handbook Procedure 1.130-E1 (Exhibit: Authorization to Provide Diabetes Care, Release of Health Care Information, and Acknowledgement of Responsibilities).

***For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:***

I authorize the School District and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-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-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 or epinephrine auto-injector.**

\_\_\_\_\_  
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 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.

\_\_\_\_\_  
Parent/Guardian printed name

Address (if different from Student's above): \_\_\_\_\_

Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

Additional Information:  
\_\_\_\_\_  
\_\_\_\_\_

Cross-references:

PRESS 7:270, *Administering Medicines to Students*

PRESS 7:270-AP, *Dispensing Medication*

PRESS 7:270-E, *School Medication Authorization Form*