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: _____

Time interval for re-evaluation: _____

☐ 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.
In accordance with the New Asthma Action Plan Law, an Asthma Action Plan MUST be provided to the school for all students 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.

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 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. 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.

Parent(s) / Guardian(s) Signature _____

Parent(s) / Guardians(s) Name (Please Print) _____

Date _____

Alton Community Unit School District #11
Asthma Medication Authorization Form
To be filed at the student's school building

Student's Name _____ **Birth Date** _____

Address _____

Home Phone _____ **Emergency Phone** _____

School _____ **Grade** _____ **Teacher** _____

Name of Medication _____

A Physician's signature is no longer required on the Medication Authorization Form for use of an **asthma inhaler only**. However, the Parent/Guardian signature is still required and there must be a prescription label **on the inhaler itself** (not just on the box) in order to ensure the inhaler is prescribed for the student carrying it.

In accordance with the New Asthma action Plan Law, an Asthma Action MUST be provided to teh school for all students with asthma. Please request an Asthma Action Plan from the doctor. I confirm that I am primarily responsible for the 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 Alton Community Unit School District #11 and its employees 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 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. 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, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees 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.

Parent(s) / Guardian(s) Signature _____

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

Date _____