Patoka Community Unit School District #100

1220 Kinoka Road Patoka, Illinois 62875

Phone: (618) 432-5400 Fax: (618) 432-5306 Nurse's Office Fax: (618) 432-5125

School Medication Authorization Form

To be completed by the child's doctor and parent(s)/guardian(s). A new form must be completed every school year. The medication will be given by the school nurse, or in the absence of the school nurse, the building principal or his designee.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____

To be completed (please print) by student's physician, physician assistant, or advanced practice nurse:

Physician, PA, or APN: _____

Office Address: _____

Office Phone: _____ Fax number: _____

Medication Name: _____

Dosage: _____ Frequency: _____

Time(s) medication is to be administered: _____

Prescription Date: _____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day (circle one): YES or NO

Side effects, if any: _____

Other medication(s) student is receiving: _____

_____

Physician, PA, or APN's Signature **Date**

For parents/guardians of students who need to carry and self-medicate with inhaler or an Epinephrine auto-injector: I authorize Patoka School District and its employees/agents to allow my child or ward to possess and use his/her asthma medication and/or 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-school or after-school care on school-operated property. Illinois law requires Patoka School District to inform parents/guardians 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). **If you agree, please initial:** _____

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 Patoka School District and its employees and agents, in my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision manner described above), lawfully prescribed medication. **I acknowledge that it may be necessary for the administration of medication 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 Patoka School District and its employees/agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of or the child's self-administration of medication. I also consent to allow school health staff, the school principal, or his/her designee, to exchange verbal and written confidential information regarding my child's medications and health conditions with the listed provider.

_____ _____

Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**