COMMUNITY UNIT SCHOOL DISTRICT 300
AUTHORIZATION FOR THE
ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name:_____ Date of Birth:_____

Address:_____

School _____Grade:_____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Community Unit School District 300 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. **I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A CERTIFIED SCHOOL NURSE AND SPECIFICIALLY CONSENT TO SUCH PRACTICES.** 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, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

For parent(s)/guardian(s) of students who Self-Administer Asthma Medications or may use an Epinephrine Auto-Injector for Anaphylaxis:
I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her medication (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 (105 ILCS 5/22-30). Beginning fall 2010 a physician's signature is not required for Asthma Inhalers and Epinephrine Auto-Injectors if the health office has a copy of the pharmacy labeled container for the medication(s). *If you agree please initial*: _____
_____

Parent(s)/Guardian(s) Signature:_____Date:_____

Phone: Home:_____ Work:_____Cell:_____

PHYSICIAN'S ORDERS (to be completed by student's physician)

Medication:_____

Dosage:_____Frequency:_____Administration Time:_____

Diagnosis Requiring Medication:_____

Possible Side Effects:_____

Special Instructions:_____

Signature:_____Date of Signature:_____

Physician's Printed Name:_____

Office Address:_____

Office Phone:_____ Fax Number:_____