Belle Valley School District #119

2465 Amann Drive, Belleville, IL 62220 • (618) 236-5200 • FAX: (618) 236-4550 • http://www.bv119.org

R.Dane Gale, Ed.S.
Superintendent

Tamara L. Leib, Ed.D.
Principal

Cindy Callahan
Principal

School Medication Authorization Form

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

Student's Name: _____ Grade: _____

Birth Date: _____ 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:

Student's Name: _____ Birth Date: _____

Asthma/Epi-Pen Medication: (PLEASE CHOOSE ONE)

☐ 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).

_____
Parent/Guardian initials

☐ I authorize my child's asthma inhaler and/or epinephrine auto-injector to be stored in the nurse's office and administered/supervised by the nurse or district employee.

_____
Parent/Guardian initials

Please initial to indicate (a) receipt of this information, and (b) authorization for your child's asthma medication and/or epinephrine auto-injector.

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. ***I have read the policy and procedures for administration of medication in Belle Valley School District 119 and agree to abide by them.***

_____
Parent/Guardian signature Printed name Date

Address (if different from Student's above): _____

Phone: _____ Emergency Phone: _____

Please return this form to the school signed by the licensed health care provider, working within their scope of practice, and the parent/ guardian. **NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER) WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.**