Belle Valley School District 119

R.Dane Gale, Ed.S. Superintendent
Khari Grant, Ed.D. Middle School Principal
Staci Kramper, M.S. Elementary 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: _____

Birthdate: _____ 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:

2465 Amann Drive, Belleville, IL 62220

Phone: (618) 236-5200 Fax: (618) 236-4550 www.bv119.net

Student's Name: _____ Birthdate: _____

Asthma/Epi-Pen Medication ONLY: (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, on my behalf, to administer or 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 and 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 healthcare provider, working within their scope of practice, and the parent/guardian. NO MEDICATION (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ADMINISTERED WIHTOUT THE REQUIRED SIGNATURES.