**Edgar County CUSD #6**

**School Medication Authorization Form**

Fax 217-269-3231

**For OTC’s only: You should not need a doctor’s appointment to have them fill out the form. Please call your doctor’s office and ask if they will fill it out and fax it to the school for the medication you are requesting. If they agree, sign this form then simply drop if off at your doctor’s office and then ask them to fax the completed form to the school.**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This section is to be completed by physician. \*No medications can be given at school without Dr. approval.

**For ALL prescription and for ALL non-prescription medications (including inhalers and Epi-Pens)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Method of Administration**  | **Scheduled Frequency**  | **Side effects (if any)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Diagnosis(es) requiring medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of orders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For parents/guardians of students who have ASTHMA: I authorize the Edgar County CUSD #6 and its’ employees and agents, to allow my child to possess and use his/her asthma medications (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. Illinois law requires the 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 (105ILCS 5/22- 30)

**If you agree please initial**: \_\_\_\_\_\_ (Parent/guardian initial)

**By signing below, I agree:**

1.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 Edgar Co. CUSD #6 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**, and 2. To indemnify and hold harmless the Edgar Co. CUSD #6 and its’ employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

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Parent/guardian signature Date