PRINCETON ELEMENTARY SCHOOL DISTRICT 115
SCHOOL MEDICATION AUTHORIZATION FORM

Student Name _____ Birth date _____

Address _____ Home Phone _____

School _____ Grade _____ Emergency Phone _____

To be completed by the student's physician or physician's designee:

Name of Medication _____ Dosage _____

Frequency _____ Time To Be Given At School _____

Date of Prescription _____ Date of Order _____ Discontinuation Date _____

1. Diagnosis requiring medication _____
2. Possible side effects _____
3. Other medications student is receiving _____
4. Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? _____
5. May student self-administer this medication **with direct adult supervision?** _____
6. Is this student aware of the side effects and able to carry and use this medication independently? _____ (i.e. inhalers and Epipens for student's grade 5 and above)
7. Further instructions/remarks _____

_____ _____ _____
Physician's Name (Print) Physician's Signature Date

_____ _____ _____
Address Phone-Office Fax

For all parents/guardians – both parents/guardians, if available, need to read and sign

I agree that I am primarily responsible for administering medications to my child. However, if I am unable to do so or in the event of a medical emergency, I authorize Princeton Elementary School District 115 and its employees and agents to administer, attempt to administer, or allow my child to self administer (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 or supervision of medication to my child be performed by an individual other than a school nurse, and specifically consent to such practices. I agree to hold harmless and indemnify the school district and its employees and agents against any claims arising out of administration of medications, attempts to administer medication, or supervision of the child's self-administration of medication.

_____ _____
Parent/Guardian (Print Name) Parent/Guardian (Print Name)

_____ _____
Parent/Guardian (Signature) Parent/Guardian (Signature)

FOR PARENTS/GUARDIANS OF STUDENTS WHO NEED TO CARRY MEDICATION (i.e. asthma medication, EpiPen) I authorize Princeton Elementary School District 115 to allow my child to possess and use asthma medication and/or epinephrine auto-injector; while in school, while at a school sponsored activity, while under the supervision of school personnel, and before or after normal activities. Illinois law requires the school district to inform parents/guardians that it and its employees and agents incur no liability, as a result of any injury arising from a student's self-administration of medication. (105 ILCS 5/22-30) Signature Date

_____ _____