Mid-Valley Special Education Cooperative

School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s) and physician <u>only if your child is to take medications during school hours</u>. A new form must be completed at the beginning of each school year. The form will be kept in the school nurse's office or, in the absence of a school nurse, the Building Principal/Supervisor's office.

Student's Name: ______________________________ Birth Date: ______________

Address: ____

Home Phone: ____________________ Emergency Phone: ____________________

School: ____________________ Grade: ________ Teacher: ____________________

To be completed by the student's physician, physician assistant, or advanced practice RN annually:

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:

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:

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:

Physician's Printed Name: ______________________________

Office Address: ______________________________ Office Phone: ______________

Physician's signature: ______________________________ Date: ____________

For only parents/guardians of students who need to carry asthma medication or an EpiPen®:

I authorize Mid-Valley Special Education Cooperative and its employees and agents, to allow my child or ward to possess and use his or her asthma medication and/or 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 Mid-Valley Special Education Cooperative 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).

If you agree please initial: _____

Parent(s)/guardian(s)

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 Mid-Valley Special Education Cooperative 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, while under the supervision of the employees and agents of Mid-Valley Special Education Cooperative), 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 Mid-Valley Special Education Cooperative 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.

_____	_____
Parent/Guardian printed name	Parent/Guardian printed name
_____ _____	_____
Parent/Guardian signature* Date	Parent/Guardian signature* Date

- *Both parents and/or guardians, if available, should sign.*