Franklin Community Unit School District #1

STUDENT MEDICATION/TREATMENT AUTHORIZATION FORM

Name of Student	Birthdate
Address	Home Phone
City Zip	Emergency Phone
School Grade	Teacher

To be completed by the student's physician:

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 below

To be completed (only) by parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:

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).

If you agree please initial _____

_____
Parent/Guardian

For all parent(s)/guardian(s)

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 prescribed 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.

_____ _____
Parent/Guardian Printed Name

_____ _____
Address (if different from student's above) Phone

_____ _____
City Zip Emergency Phone

_____ _____
Parent/Guardian Signature Date

NOTE: All medication must be checked in with authorized school personnel (administrator, teacher, or secretary). It must be in the original container from the pharmacy indicating the name of the student and the names and phone numbers of the physician and pharmacy. Any change in the dosage or administration of the medication must have written authorization from the prescribing physician. Continuing long-term medication must be re-verified at the beginning of each school year.