District No. 105 Form 7270

HEALTH SERVICES

La Grange, IL

☐ GURRIE
☐ HODGKINS
☐ IDEAL
☐ SEVENTH AVENUE
☐ SPRING AVENUE

La Grange School District 105

FAX NUMBERS

GURRIE: (708) 482-2724 **HODGKINS** (708) 482-2728
IDEAL (708) 482-2729 **SEVENTH AVENUE** (708) 482-2726
SPRING AVENUE 708) 482-2725

Grade/Teacher _____

School Year _____

SCHOOL MEDICATION AUTHORIZATION FORM

Student's Name:_____ **Birth Date**:_____

Address:_____

Home Phone: _____ **Cell Phone:** _____ **Emergency Phone**:_____

TO BE COMPLETED BY STUDENT'S PHYSICIAN, PHYSICIAN'S ASSISTANT WITH PRESCRIPTIVE AUTHORITY, OR ADVANCE PRACTICE RN WITH PRESCRIPTIVE AUTHORITY. (NOTE-FOR ASTHMA INHALERS WITH PRESCRIPTION LABEL ONLY-USE THE ASTHMA INHALERS SECTION BELOW).

A NEW FORM MUST BE COMPLETED EVERY SCHOOL YEAR. KEEP IN SCHOOL NURSE'S OFFICE.

Is it necessary for this medication to be administered during the school day (circle one): Yes No

Diagnosis Requiring Medication _____

MEDICATION NAME	DOSAGE	FREQUENCY	TIME MEDICATION IS TO BE ADMINISTERED OR UNDER WHAT CIRCUMSTANCES	PURPOSE	EXPECTED SIDE EFFECTS, IF ANY

_____
Prescriber's Initials

This student has been instructed in the self-administration of the above **asthma or epi-injector** medication and knows the circumstances under which to use the medication. Student must carry the medication during school. **Note: It is strongly recommended that an extra inhaler or epi-injector be kept in the school nursing office.**

Prescription Date: _____ **Order Date**:_____ **Discontinuation Date:** _____

Time Interval for Re-Evaluation:_____

Other Medications Student Is Receiving: _____

_____
DATE

_____
PRESCRIBER'S SIGNATURE

_____
PRINTED NAME OF PRESCRIBER

_____
OFFICE ADDRESS

_____
OFFICE PHONE & EMERGENCY TELEPHONE NUMBER (IF DIFFERENT)

APPROVED:

_____
School Nurse

_____
Date

(OVER)

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(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

Asthma Inhalers

Parent(s)/Guardian(s) please attach prescription label here:

For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine injector:
I authorize School District 105 and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine 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-carry and self-administration of asthma medication or epinephrine injector 105 ILCS 5/22-30. Amended by P.A.s 100-726 and 100-799. eff. 1-1-19.
Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine injector

_____
Parent/guardian initials

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 School District 105 and its employees and agents, on 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 School District 105), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors or undesignated asthma medications when there is a good faith belief that my child is having an anaphylactic reaction or respiratory distress, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799. eff. 1-1-19. I acknowledge that a required EMS/911 call will be made if my child requires administration of an undesignated epinephrine injector or undesignated asthma medication. The school district, its employees and agents, and/or physician(s)/individual(s) with prescriptive authority providing the standing protocol and prescription for the District's supply of undesignated epinephrine injectors and undesignated asthma medications, are protected from liability, except for willful or wanton conduct arising from the use of an undesignated epinephrine injector or undesignated asthma medication regardless of whether authorization was given by the student, parent/guardian, or student's physician. Additionally, the parent/guardian of the student must indemnify and hold harmless the school district and its employees and agent, against any claims, except a claim based on willful and wanton conduct, arising out of the administration of an epinephrine injector or asthma medication regardless of whether authorization was given by the student's parent/guardian or by the student's physician, physician's assistant, or advanced practice registered nurse. **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 School District 105 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): _____

Home Phone: _____ **Cell Phone:** _____ **Emergency Phone:** _____

_____ _____
Parent/Guardian Signature **Date**