

Laboratory Schools Medication Authorization Form

This authorization is for students that need medication dispensed at school or for self-carry of medications such as asthma medication, epinephrine, etc. You have already received information regarding the Laboratory School's policies and procedures for administration of undesignated emergency medications as part of the registration process.

All prescription medications to be administered at school must be in the original pharmacy labeled container. Over the counter medication must be in the original container with the child's name affixed to the container. All medications (prescription and nonprescription) are generally required to be kept locked in the nurse's office or in the school office when not in use, unless the student has permission to self-administer the medication as outlined in this form. Unless ordered for a short term, all requests for self-administration of medication will expire at the end of the school year unless needed for school related summer programs. New forms are required at the beginning of each school year. If the parent/guardian does not pick up any unused medication after notification, the School Nurse shall dispose of the medication. All questions regarding medication administration may be directed to the Laboratory School Nurse at 309-438-2435.

To be completed by the child's parent(s)/guardian(s).

Student's Name: _____ Birth Date: _____

School: _____ Grade: _____ Teacher: _____

Known Allergies: _____

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority.

Prescriber's Printed Name: _____

Office Address: _____ Phone Number: _____

Medication Name: _____

Purpose of Medication/Diagnosis: _____

Dosage: _____ Time of Administration: _____

If medication is to be given "as needed", describe circumstances: _____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

Length of time this treatment is recommended: _____

List significant side effects: _____

Other Medication Student is receiving: _____

Is it necessary for this medication to be administered during the school day in order to allow the child to attend school or to address the student's medical condition that may arise at school? _____

Does medication qualify for or is part of an emergency action plan? _____

If Yes, please provide a copy of the plan. (ie. Asthma Action plan, Food Allergy Action Plan, Seizure Action Plan, Diabetes Medical Management Plan)

Signature of Physician, Physician Assistant, or Advanced Practice RN ONLY: _____

Date: _____

GENERAL MEDICATION AUTHORIZATION

It is the policy of the State of Illinois that the administration of medication to students during regular school hours and during school-related activities should be discouraged unless absolutely necessary for the critical health and well-being of the student. 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 Laboratory Schools 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 the Laboratory Schools), lawfully prescribed medication in the manner described. 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. I further consent to the sharing of relevant medical information between the school and the physician's office.

SELF-CARRY & SELF-ADMINISTRATION MEDICATION AUTHORIZATION

For parents/guardians of students who grant permission for their student to self-carry and self-administer asthma medication or an EpiPen:

I authorize the Laboratory Schools and its employees and agents, to allow my child to self-carry and self-administer their asthma medication and/or epinephrine injector while in school, while at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before school or after school care on school operated property. This permission shall be effective for the school year in which it is granted. Illinois law requires the Laboratory School 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 prescribed asthma medication or epinephrine injector. (105 ILCS 5/22-30).

For parents/guardians of students who will self-carry asthma medication please provide the prescription label of the medication.

If applicable, **please initial** to indicate authorization for your child to carry and use his or her asthma medication or epinephrine injector: _____

I acknowledge and agree to the above statements.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Primary Phone: _____ Emergency Phone: _____