

School Medication Authorization Form

To be completed by the student's parent(s)/guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the building principal's office.

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Physician's printed name:		
Office Address:	Office Phone:	
Medication:		
Dosage:	Frequency:	
Time medication is to be administered or under what circumstances:		
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Expected side effects if any:		
Time interval for re-evaluation:		
Has student been taught to self administer this medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does student have your approval to administer this medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other medication student is receiving:		

Physician's Signature

Date

By signing below, I agree:

1. 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 95 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of District 95), 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**
2. To indemnify and hold harmless District 95 and its employees and agents any claims, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the student.

Parent/Guardian printed name

Parent/Guardian printed name

Parent/Guardian signature

Parent/Guardian signature

LZHS NURSE'S OFFICE FAX: 847-540-4190
Please Note: a separate form is required for each medication.
PLEASE COMPLETE BOTH SIDES

***For parent(s) / guardian(s) of students who have asthma, diabetes
or are subject to severe allergic reactions:***

I authorize the School District 95 and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, diabetic supplies or "Epi-Pen" (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 (105 ILCS 5/22-30).

If you agree please initial: _____
Parent(s)/Guardian(s) initial

**COMPLETED FORMS MAY BE RETURNED BY FAX
LAKE ZURICH HIGH SCHOOL NURSE'S OFFICE FAX: 847-540-4190
SEND BOTH SIDES**

Please note: A separate form is required for each medication
PLEASE COMPLETE BOTH SIDES