Arthur Community Unit School District #305

School Medication Authorization Form

No Prescribed or Over the Counter medication will be administered until this form is completed, signed by Physician and parent, and returned to the school office. All medications must be furnished by the parent and brought to the school office. The container should be appropriately labeled by a pharmacy or an original bottle with the student's name on the bottle (blister packs are highly recommended). All medication is kept in a safe that has a limited space, please send small bottles and no more than a 30 day supply.

To be completed by the students Parent(s)/Guardian(s). A new form must be completed every school year.

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 Nurse for ALL Prescribed and Over the Counter medications (ex: Acetaminophen, Ibuprofen, Antacid (Tums), and Benadryl:
Physician's Printed Name_____
Office Address: _____Office Phone: _____
Medication #1
Medication Name: _____ Dosage: _____
Frequency: _____Purpose:_____ Physician Initials _____
Time medication is to be administered or under what circumstance:_____
Diagnosis requiring medication: _____
Expected side effects, if any: _____
Medication #2
Medication Name: _____ Dosage: _____
Frequency: _____Purpose:_____ Physician Initials _____
Medication #3
Medication Name: _____ Dosage: _____
Frequency: _____Purpose:_____ Physician Initials _____

For High School 9th-12th Grade
____ Tylenol 500 mg 1 or 2 po every 6 hrs as needed
____ Ibuprofen 200 mg 1 or 2 po every 6 hrs as needed
____ Antacid (Tums) 2 tabs po as needed for indigestion or upset stomach
____ Cough Drops as directed on package

_____ _____
Physician's Signature **Date**

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 the School District and its employees and agents, in my behalf, 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 the School District), 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 that a school health aide 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 **Parent/Guardian Signature** **Date**

Arthur Community Unit School District #305

Asthma Inhalers/EpiPens

For only Parents/Guardians of students who need to carry Asthma Medication or an EpiPen:

I authorize the School District 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 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. I understand that administration by school personnel may be performed by an individual other than a certified and registered school nurse, and I specifically consent to this. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration or self administration of said medication, and agree to hold harmless and indemnify the School District #305, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self administration of medication. 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).

For Asthma Medication/Epinephrine injectors only: I consent to my child's possession and unsupervised self-administration of medication. ____ Yes ____No

Signature of Parent: _____ Date: _____

Phone: _____