



**Riverside Public Schools
District 96**

SCHOOL/PHYSICIAN/PARENT MEDICATION AUTHORIZATION FORM

Student Name:		Date of Birth:	
School:		Grade:	

I hereby confirm primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Riverside Public Schools District 96 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 the Riverside Public Schools District 96, 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 OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, or attempted to be administered, I waive any claims I might have against Riverside Public Schools District 96, its employees and agents, either jointly or severally, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, or attempt at administration, of said medication.

I hereby grant Riverside Public Schools District 96 permission to contact the physician prescribing the medication for my child when deemed necessary.

Parent/Guardian Signature

Date

**TO BE COMPLETED BY THE STUDENT'S PHYSICIAN AND PARENT FOR ALL
PRESCRIPTION AND NON-PRESCRIPTION MEDICATION:**

Medication	Dose	Frequency	Time	PRN/Daily	Stop Date	Side Effects

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? ☐ **YES** ☐ **NO**

Physician's Name—Print

Physician's Name—Signature

Telephone Number:

Date



**Riverside Public Schools
District 96**

SCHOOL MEDICATION AUTHORIZATION FORM

For Self Administration of Emergency Asthma Medication Inhaler and/or an Epinephrine Auto-Injector *ONLY*:

***I certify that this student has been instructed in the use and self-administration of their emergency asthma medication and or epinephrine auto-injector. He/She understands the need for the medication and the necessity to report to school personnel any utilization of the medication and/or any unusual side effects. He/She has been given instructions and is capable of using this medication independently.**

1. Will this student self carry medication? ☐ YES ☐ NO
2. Will a second set of medication be kept in the health office at school? ☐ YES ☐ NO

Physician's Name (Printed)

Physician's Signature

Telephone Number

Date

Medication Authorization

MEDICATION

Public Act 87-790 (effective January 1, 1992), states that, "It shall be the policy of the State of Illinois that the administration of medication to students during regular school hours and during school related events should be discouraged unless absolutely necessary for the critical health and well being of the student." Parents/Guardians have primary responsibility for administering medication to their children. Only those medications absolutely required for the critical health and well-being of the student will be administered during school hours or during school related activities. In order to insure the safe and proper administration of medication to students, the following procedures have been established in accordance with the guidelines from the State Superintendent of Education for the State of Illinois and policies of the Board of Education. The intent of these procedures is to protect the student, to provide a clear and consistent approach to the administration of medication and to ensure the physician, parents, school, and student understand their responsibilities.

Self Administration of Asthma Medication and/or Epinephrine Auto-Injector

Under Public Act 92-0402 and 94-0792, students are permitted to self-administer asthma medication and/or an epinephrine auto-injector provided that:

1. The parent/guardian of the pupil provide to the school written authorization for self-administration of medication; and
2. The parent/guardian of the pupil provide the school a written statement from the pupil's physician, physician assistant, or advanced practice registered nurse containing the following information:
 - A. name of the medication
 - B. prescribed dosage
 - C. time or times at which or the special circumstances under which the medication is to be administered.



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Procedure:

1. The Parent/Guardian and Illinois physician will complete the School Medication Authorization Form before the administration of any non-prescription or prescription medication at school. The School Medication Authorization Form must be completed by parent/guardian and physician to continue administration beyond the initial day.
2. All medications will be provided to the school nurse in an original container or vial, as provided by the pharmacist, with the prescription/dosage affixed. Upon request, the pharmacist will supply you with two properly labeled containers, one for home use and one for use at school. Non-prescription (over-the-counter) medications must be provided in the original container labeled with the student's name.
3. The School Medication Authorization Form must be completed annually (annually meaning with the beginning of each new school year) or whenever there is a change in medication and /or dosage.
4. No student may possess or consume any prescription or non-prescription medication during school hours or school related activities until a completed and signed School Medication Authorization Form is on file. The school nurse may, in conjunction with the physician and parent/guardian, identify circumstances in which a student may self-administer medication either under the direct supervision of school personnel in-serviced by the school nurse, or through an individualized program developed by the school nurse.
5. The parent/guardian is responsible for bringing medication to the school and for taking unused medication from the school when no longer required.
 - a. Medication will only be received by and/or returned to the parent through the nurse, building administrator or assigned personnel.
 - b. Upon drop off, medication is required to be counted by the nurse and/or building administrator or assigned personnel in the presence of the parent and the parent will be asked to sign off on the amount being supplied to the school for administration.
6. Medication will be administered under the direction of the school nurse and/or building administrator or assigned personnel.
7. NO herbal, vitamin or mineral supplements will be administered during school hours.

I have read the District 96 Medication Policy and understand my responsibility and my child's responsibility in adherence to it's directives. I completely release and excuse District 96 and its employees of any liability in any way related to the medication policy and procedures.

Printed Name of Parent: _____

Address: _____

Phone Number: _____ Work Phone Number: _____

Parent/Guardian Signature

Date