

AEC School Medication Authorization Form

Required when a student needs to take either prescription or non-prescription medication during the school day.

Student's Name:

Birth Date:

Grade:

Home School:

Parent Cell Phone Number:

Emergency Cell Number:

Below must be completed by the student's physician, physician assistant, or advanced practice RN.

(Note: for asthma inhalers only, use the "Asthma Inhalers" section below):

Physician's Printed Name:

Office Address:

Office Phone Number:

Emergency Office Phone Number:

Medication Name:

Dosage:

Frequency:

Discontinuation Date:

Time medication is to be administered or under what circumstances:

Diagnosis (if applicable) requiring medication:

Is it necessary for this medication to be administered during the school day? Yes No

Expected side effects, if any:

Physician's Signature:

Date:

Student's Name:

Birth Date:

Asthma/Epi-Pen Medication:

I authorize the School District and its employees and agents, to allow my child or ward to self-administer his or her asthma inhaler and/or use his or her epinephrine auto-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-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

Parent/Guardian Initials: _____

I authorize my child's asthma inhaler and/or epinephrine auto-injector to be stored in the AEC's office and administered/supervised by district employees.

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 Alternative Education Center and its employees and agents, in 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 St. Clair County Regional Office of Education, AEC 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 I agree to indemnify and hold harmless AEC 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. *I have read the policy and procedures for administration of medication at the Alternative Education Center.*

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Address (if different from Student's above): _____

Cell Phone Number: _____

Please return this form to the school signed by the licensed health care provider, working within their scope of practice, and the parent/ guardian. **NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER) WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.**