**Jasper County Community Unit Schools**
**School Medication Authorization Form**

***To be completed by the child's parent(s)guardian(s).*** ***A new form must be completed every school year.***

Student's Name:____________________________________________Birth Date:_____________________________________________

Address:______________________________________________________________________City:______________________________

Home Phone:___________________________________Cell Phone:______________________Emergency Phone:___________________

School:_______________________________Grade:____________________Teacher:___________________________________________

***To be completed by the student's physician, physician assistant, nurse practitioner, or advanced practice R.N.***

Physician's Printed Name:__________________________________________________________________________________________

Office Address:______________________________________________________________________City:___________________________

Office Phone:_____________________________________________Emergency Phone:_______________________________________

**Medication #1**

Medication Name:__________________________________________Purpose:_____________________________________________

Dosage:___________________________________________Frequency:_____________________________________________________

Time medication is to be administered and under what circumstances:_________________________________________________

____________________________________________________________________________________________________________

Prescription date:__________________________Order date:______________________Discontinuation Date:___________________

Diagnosis requiring medication:_______________________________________________________________________________

Is it necessary for this medication to be administered during the school day? Yes________________No_____________________

Expected side effects, if any:___________________________________________________________________________________

Time interval for re-evaluation:_________________________________________________________________________________

**Medication #2**

Medication Name:__________________________________________Purpose:_____________________________________________

Dosage:___________________________________________Frequency:_____________________________________________________

Time medication is to be administered and under what circumstances:_________________________________________________

____________________________________________________________________________________________________________

Prescription date:_________________________Order date:______________________Discontinuation Date:___________________

Diagnosis requiring medication:_______________________________________________________________________________

Is it necessary for this medication to be administered during the school day? Yes_________________No____________________

Expected side effects, if any:___________________________________________________________________________________

Time interval for re-evaluation:_________________________________________________________________________________

**Medication #3**

Medication Name:__________________________________________Purpose:_____________________________________________

Dosage:___________________________________________Frequency:_____________________________________________________

Time medication is to be administered and under what circumstances:_________________________________________________

____________________________________________________________________________________________________________

Prescription date:________________________Order date:______________________Discontinuation Date:_____________________

Diagnosis requiring medication:_______________________________________________________________________________

Is it necessary for this medication to be administered during the school day? Yes_________________No_____________________

Expected side effects, if any:___________________________________________________________________________________

Time interval for re-evaluation:_________________________________________________________________________________

Other medications student is receiving:___________________________________________________________________________

____________________________________________________________________________________________________________

**Physician's Signature** **Date**

***Reverse side of form must be completed***

**For only parents/guardians of students who need to carry asthma medication or an EpiPen:**

I authorize the Jasper Unit #1 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:

________while in school

________while at a school-sponsored activity

________while under the supervision of school personnel

________before or after normal school activities such as 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 5/22-20). If you agree please initial:

_______________________________________________

Parent(s)/Guardian(s)

**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 (Jasper Unit #1) 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, while under the supervision of the employees and agents of Jasper Unit #1), 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 Jasper Unit #1 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 printed name

_______________________________________________

Parent/Guardian signature*          Parent/Guardian signature*

_______________________________________________

Date          Date

*both parents and/or guardians, if possible, should sign.