

# SCHOOL MEDICATION AUTHORIZATION FORM

Carbon Cliff Barstow School District #36 – Eagle Ridge School

2002 Eagle Ridge Drive, Silvis, IL 61282

Phone: (309) 792-2002 / Fax: (309) 792-2242

**TO BE COMPLETED BY THE STUDENT'S PARENT(S)/GUARDIAN(S)**  
**A new form must be completed every school year and with any medication change**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER**

PROVIDER'S PRINTED name: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
Office address: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
Medication name: \_\_\_\_\_ Purpose: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Time medication is to be administered and/or under what circumstances: \_\_\_\_\_  
Prescription date: \_\_\_\_\_ Order date: \_\_\_\_\_ Discontinuation date: \_\_\_\_\_  
DIAGNOSIS requiring medication: \_\_\_\_\_  
Expected side effects: \_\_\_\_\_  
Is it necessary for this medication to be administered during the school day?  Yes  No  
Other medications student is receiving: \_\_\_\_\_  
Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

**The medication must be in the original labeled container as dispensed or the manufacturer's labeled container. The medication label must contain the student's name, name of the medication, directions for use and date. Annual renewal of authorization and immediate notification, in writing, of changes.**

**For only parents/guardians of students who need to carry ASTHMA MEDICATION or an EPINEPHRINE AUTO-INJECTOR:**

I authorize the School District and its employees and agents, to allow my child to carry and self-administer their asthma inhaler and/or use their epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, or (3) while under the supervision of school personnel during school hours. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability. I agree to hold harmless and indemnify the *Carbon Cliff-Barstow School District, Eagle Ridge School*, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Physician's signature \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

**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 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.** I agree to hold harmless and indemnify the *Carbon Cliff-Barstow School District, Eagle Ridge School*, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Printed Name \_\_\_\_\_  
Address (if different from Student's above): \_\_\_\_\_  
Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_