FENTON COMMUNITY HIGH SCHOOL DISTRICT 100
1000 WEST GREEN STREET
BENSENVILLE, IL 60106

SCHOOL MEDICATION AUTHORIZATION FORM

To be completed by the child's parent(s)/guardian(s). Please note a new form must be completed every school year.

Student's Name: _____Birth Date:_____Grade:_____

Address: _____

Home Phone_____Emergency Phone_____

To be completed by the student's physician, physician assistant, or advanced practice RN (Note: for asthma inhalers only, use the "Asthma Inhalers" section below):

Medication_____

Diagnosis_____

Purpose:_____

Dosage:_____Frequency:_____

Time medication is to be administered or under what circumstances:

_____

Expected side effects, if any_____

Physician's Printed Name:_____

Office Address:_____

Office Phone:_____

_____ _____
Physician's signature Date

Asthma Inhalers

Parents/Guardians please attach prescription label here:

Parent/Guardian additional information to be completed on reverse side.

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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 to allow my child to *self-administer* pursuant to State law, 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 than a school nurse 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 of the child's self-administration of medication, and

I authorize information provided to be shared with Fenton High School staff as needed to ensure the safety and well being of the student.

_____
Student Name

_____
Parent/Guardian printed name

Emergency Phone_____

_____ _____
Parent/Guardian signature Date

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 or ward to carry and 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).

Initials:_____
Parent/Guardian