SD308
COMMUNITY UNIT SCHOOL DISTRICT

SCHOOL MEDICATION AUTHORIZATION FORM

Student Information			
Name		**Birthdate**	
School		**Grade**	
Parent name		**Parent phone**	

For all parents/guardians:

1. All medications, including prescription and over the counter medications that are required to be administered during the school day will only be administered once the **SCHOOL MEDICATION AUTHORIZATION FORM** has been completed and filed in the health office.
2. **ALL** prescription medication must be brought to school by a parent/guardian in the original pharmacy packaging with the prescription label legible and intact that includes:
   - Student Name
   - Prescription Number
   - Medication Name/Dosage
   - Administration Route and/or other direction
   - Date(s) and Time(s) to be taken
   - Licensed Prescriber's Name
   - Pharmacy Name, Address and Phone Number
3. **ALL** *over the counter* medication must be brought to school by a parent/guardian in the original, sealed over the counter bottle with the student's name affixed.
4. Medications will be stored in the health office.
5. Students are prohibited from carrying any medications with them during the school day unless otherwise agreed upon by the school health staff and parent/guardian.
6. Unused medications must be picked up by a parent/guardian before school ends on the last day of the school year. Any medications not picked up by a parent/guardian will be disposed of by the school nurse.

By signing below, I acknowledge 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 CUSD 308 and its employees/agents to administer or 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/agents of the District), lawfully prescribed medication as indicated by their medical care provider on the following page. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication to my child when there is good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not, and if applicable, undesignated glucagon when authorized by my child's diabetes care plan and if my child's glucagon is not available on-site or has expired. 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 indemnify and hold harmless CUSD 308 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 signature Date

Home Phone: _____ Cell Phone: _____

Enter each medication in a separate box below. Use additional forms as necessary.

To be completed by student's physician, physician assistant, or advanced practice RN with prescriptive authority

Licensed prescriber's order for medication			
Medication name and purpose		**Dosage /frequency**	
Diagnosis			
Start/end date	• **Use school start/end dates**		
Prescriber signature:		**Date**	
Prescriber name:		**Prescriber address:**	

Licensed prescriber's order for medication			
Medication name and purpose		**Dosage /frequency**	
Diagnosis			
Start/end date	• **Use school start/end dates** •		
Prescriber signature:		**Date**	
Prescriber name:		**Prescriber address:**	

Licensed prescriber's order for medication			
Medication name and purpose		**Dosage /frequency**	
Diagnosis			
Start/end date	• **Use school start/end dates**		
Prescriber signature:		**Date**	
Prescriber name:		**Prescriber address:**	

I hereby authorize that the following student _____ shall be allowed to self-carry his/her epinephrine auto injector or rescue inhaler or other medication to be used as needed during the school day as indicated in their individual Asthma Action Plan, Allergy Action Plan, or 504 Plan.

_____
Physician signature Date

_____
Parent signature Date