

**FOREST BLUFF SCHOOL
MEDICATION AUTHORIZATION FORM**

Due to the School Office by student's first day of school

This form is valid for one year from the date of signatures. Any changes in medication, dosage, schedule, or administration requires a new form.

This page to be completed by licensed prescriber for *ALL medications, including over-the-counter*:

Student Information:

Name of Student: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Special Circumstances Requiring Medication: _____
(diagnosis, condition, or syndrome)

Licensed Precrifier's Statement and Medication Information:

I, the above named student's licensed prescriber am requesting that the above named student receive the following medication, during school hours:

Name of Medication: _____ Dosage: _____ Route: _____

Time to be Given & Frequency:

Other Medications Student is Taking: _____

Possible Side Effects: _____

For Asthma Medication/Epinephrine Auto-Injectors Only:

Is self-carry authorized? Yes No

Is unsupervised self-administration authorized? Yes No

My contact information in case of an adverse reaction, emergency, or for questions is:

Physician's Name (print): _____

Name of Practice or Hospital Affiliation: _____

Address: _____ Phone #: _____

Physician's Signature: _____

Date: _____

MEDICATION AUTHORIZATION FORM (cont.)

This page to be completed by the student's parent(s) or guardian(s):

For All Medications:

I, _____, parent or guardian of _____, hereby authorize Forest Bluff School and its employees and agents to administer to my child, prescribed medication in the manner described above. I will be responsible for bringing and removing all prescription and non-prescription medications in its original container labeled by the pharmacy. I also authorize the school's nurse to consult with the above licensed prescriber regarding any concerns about this medication.

Parent/ Guardian Signature: _____ Date: _____

For Asthma Medication and/or Epinephrine Auto-Injectors Only:

I authorize Forest Bluff School and its employees and agents, to allow my child to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine (EpiPen) 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, on school-operated property. Illinois law requires Forest Bluff School, and all other non-public schools, 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. ***If you agree, please initial:*** _____

Parent/Guardian

Please attach **asthma inhaler prescription label** here:

For All Parent(s)/Guardian(s):

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 Forest Bluff School 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 Forest Bluff School), 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 certified school nurse and specifically consent to such practices**, and I agree to indemnify and hold harmless Forest Bluff School 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 Name (print): _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____