Polo Community School District #222
School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year.
Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____	Birth Date: _____
Address: _____	
Home Phone: _____	Emergency Phone: _____
School: _____	Grade: _____ Teacher: _____

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 name: _____	
Purpose: _____	
Dosage: _____	Frequency: _____
Time medication is to be administered or 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:
Physician's Printed Name: _____	
Office Address: _____	
Office Phone:	Emergency Phone:

Asthma Inhalers: Parent(s)/Guardian(s) please attach prescription label on back.
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). ***If you agree please initial:*** _____
Parent/Guardian

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 or the child's self-administration of medication.

_____
Parent/Guardian printed name

Address (if different from Student's above): _____

Phone: _____ Emergency Phone: _____

_____ _____
Parent/Guardian signature Date