NEOGA CUSD #3

MEDICATION AUTHORIZATION FORM

Phone (217)895-5500 fax (217)895-3957

A new form must be completed every school year.

No medication can be given at school without Dr. approval.

Student Name: _____Grade: _____

Birth Date: _____ Parent Name:_____Phone:_____

***Prescription medication container shall display**: student's name, prescription number, medication name and dosage, administration route or other directions, date and refill, licensed prescriber's name, pharmacy name, address and phone number, name or initials of pharmacist.
***Over-the-counter medication** shall be brought in with the manufacturer's original label with the ingredients listed and the child's name affixed to the container.

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*To be completed by Physician/PA/NP

For Prescription and Non-Prescription Medication (including inhalers and Epi-Pens)

Medication	Dose	Method of Administration	Scheduled Frequency	Side Effects (if any)

Diagnosis(es) requiring medication: _____

Prescribing Professional's name (printed):_____

Prescriber's Signature:_____

Date of orders: _____Phone:_____

Comments:_____Discontinuation of order date:_____

For only parent/guardians of students who need to carry asthma medication or 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:_____

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, on 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 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 Signature_____ Date: _____