NORTH MAC COMMUNITY DISTRICT NO. 34
SCHOOL MEDICATION AUTHORIZATION

Superintendent Office	Elementary School Office	Intermediate School Office	Middle School Office	High School Office
Phone: 627-2915	Phone: 965-5424	Phone: 627-2419	Phone: 627-2136	Phone: 965-4127
Fax: 627-3519	Fax: 965-4342	Fax: 627-3409	Fax: 627-3503	Fax: 965-4006

To be completed by the student's parent(s) or guardian(s):

Student's Name: _____ Birthdate: _____
Address: _____
Home Phone Number: _____ Emergency Phone Number: _____
School: _____ Grade: _____ Teacher: _____

For only parent(s) or guardian(s) of students who need to carry asthma medication or an EpiPen: I authorize the school district and its employees and agents, to allow my child or ward to possess and use his/her asthma medication and/or 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) or 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(s) or Guardian(s)**

For all parent(s) or 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 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, 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 employee 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.

_____ _____
Printed Name of Parent or Guardian Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Signature of Parent or Guardian

To be completed by the student's physician, physician assistant, or advanced practice RN:

Physician's Printed Name: _____
Office Address: _____
Office Phone Number: _____ Emergency Phone Number: _____
Medication Name: _____
Dosage: _____ Purpose: _____
Time or under what circumstances to be administered: _____
Prescription Date: _____ Order Date: _____ Discontinuation Date: _____
Necessary to be administered during the school day? _____YES _____NO
Time Interval for Re-evaluation:_____ Other Medication Taking: _____

_____ _____
Physician's Signature Date

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