Salt Fork CUSD # 512

Unit Office
701 ½ West Vermilion
Catlin, IL 61817
217-427-2116; Fax 217-427-2117
South Campus Elementary/Jr. High: 217-288-9394; Fax: 217-288-9395
North Campus Elementary: 217/427-5421; Fax: 217-427-9866
North Campus High School: 217/427-5331; Fax: 217-427-2468

SCHOOL MEDICATION AUTHORIZATION FORM

Parent/guardian please complete and return to school nurse. A new form must be completed every school year.

Student Name: _____ Birth date: _____

Address: _____ Phone: _____

Emergency Phone: _____ Contact: _____

School: _____ Grade: _____ Teacher: _____

To be completed by Physician, Physician Assistant, or Advanced Practice RN

Name of Medication: _____

Dosage: _____ Frequency: _____ Route: _____

Diagnosis: _____

Possible Side Effects: _____

Start Date: _____ Stop Date: _____

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Physician Signature: _____ Date: _____

ASTHMA INHALERS/EPI-PENS

For parents of students who carry asthma medications or an epinephrine auto-injector:
I authorize the Salt Fork 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 and 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)

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his/her asthma medication or epinephrine auto-injector.
_____ (parent/guardian initial)

I authorize the following over the counter medications to be given to my child:

_____Acetaminophen (Tylenol) _____ Benadryl

_____Ibuprofen (Advil, Motrin) _____ antacid (Tums)

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event 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**.** This includes administration of undesignated epinephrine auto-injectors when there is a good faith belief that my child is having an anaphylactic reaction, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse and specifically consent to such practices,** and I agree to indemnify and hold harmless the Salt Fork School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the child's self-administration of medication.

Parent/Guardian Signature: _____ Date: _____

Address: _____ Phone: _____