Authorization for Medication Administration

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			☐ Male ☐ Female	

Parent/Guardian Name	Parent / Guardian Phone Number
Physician Name	**Physician Phone Number**

(105 ILCS 5/10-22.21b) (from Ch. 122, par. 10-22.21b) Sec. 10-22.21b. Administering medication. To provide for the administration of medication to students. It shall be the policy of the State of Illinois that the administration of medication to students during regular school hours and during school-related activities should be discouraged unless absolutely necessary for the critical health and well-being of the student. Under no circumstances shall teachers or other non-administrative school employees, except certified school nurses and non-certificated registered professional nurses, be required to administer medication to students. This Section shall not prohibit a school district from adopting guidelines for self-administration of medication by students. This Section shall not prohibit any school employee from providing emergency assistance to students. (Source: P.A. 91-719, eff. 6-2-00.)

PHYSICIAN ORDER

I have examined student for (diagnosis) ______________________ and have determined that he/she requires medication during school hours.

Name of Medication: ____

Dosage: _____________________ **Route**: _____________________________ **Time of administration**: ____________________

Side Effects:____

Special instructions regarding this medication: ____

Contact me if the following signs or symptoms develop: ____

The student is also taking the following other medications: ____

Please indicate if the student is able to self-administer this medication.

☐ **This student may self-administer this medication.** ☐ **This student cannot self-administer this medication**

______________________________ ______________________________ _______________

Healthcare Provider Signature **Healthcare Provider Printed Name** **Date**

__________________________ _________________________________ ____________________________________

Phone **Fax** **Email**

PARENT/GUARDIAN STATEMENT:

1. I, the undersigned parent/guardian of the above named student, hereby request the school nurse to administer the above medication according to the healthcare provider's instructions (above).
2. I agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement medication as necessary and to notify the school nurse immediately if the provider or medication prescription is changed or discontinued.
3. I authorize, as needed, the sharing of information related to my child's health between the school nurse (and designee) and the health care provider listed on this form. I understand without this authorization to communicate these orders will not be implemented.

______________________________ ______________________________ _______________ __________

Parent/Guardian Signature **Parent/Guardian Print Name** **Phone Number** **Date**

Use separate forms for different medications. This form must be completed and returned to School Health Office before the medication can be given. This document must be renewed annually.