

Authorization for Medication Administration

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			<input type="checkbox"/> Male <input type="checkbox"/> 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.		
<input type="checkbox"/> This student may self-administer this medication. <input type="checkbox"/> 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
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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.