School Medication Authorization Form – Valley View School District 365U ("VVSD 365" or "School District")

This form is to be used for medication other than medical cannabis. A new form must be completed every school year for each medication.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

(*To be completed and signed by prescribing physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority*)

Student name: _____ DOB:_____ Grade: _____

Medication name:_____

Purpose of medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered and under what circumstances:

_____

Diagnosis requiring medication: _____

Prescription date: _____ Order date: _____ Discontinuation date: _____

Intended effect: _____

Possible side effects: _____

Time interval for re-evaluation: _____

Other medications student is receiving: _____

Special considerations: _____

All medication administered in school must be in the original container, properly labeled by a pharmacist.

_____ _____

Physician signature Date

Physician name: _____

Address: _____

Phone #: _____ Fax: _____

AUTHORIZATION FOR THE SELF-ADMINISTRATION OF EPINEPHRINE, INSULIN, ASTHMA MEDICATION OR MEDICATION REQUIRED UNDER A QUALIFYING PLAN

(*To be signed by prescribing physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority where it is necessary for student to self-administer their medication during the school day*)

I certify that the identified student has been instructed in the use and self-administration of their medication. They understand the need for the medication and the necessity to report to school personnel any unusual side effects. The student is capable of using this medication independently.

_____ _____

Physician signature Date

School name: _____ **Nurse's name:** _____

Phone number: _____ **Fax number:** _____

Parental Authorization for the Administration of Medication in School

VVSD 365 believes that medication should be administered in the home when at all possible. However, if your child's health care provider determines that it is necessary for your child to receive medication during the school day, a medication authorization with specific directions must be provided to school personnel. It is important to note that students are not automatically authorized to carry medication or keep medication in their locker. Only students who are authorized to self-administer epinephrine, insulin and/or asthma medications pursuant to the relevant regulations on self-administration are permitted to carry those medications on their person.

Medications should be brought to school in the original container, appropriately labeled by the pharmacy, and clearly stating the student's name, name of the medication, the prescribed dosage, the time at which or circumstances under which the medication is to be administered, and the date of expiration. Over-the counter medications, which also require authorization by a licensed health care provider, must have the original label by the manufacturer with the student's name clearly marked on the container.

To be completed and signed by the student's parent or guardian:

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 request and grant permission for VVSD 365 and its employees and agents, on my behalf, to administer, or 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 VVSD 365, lawfully prescribed medication in the manner described on the preceding page. I authorize VVSD 365 and its employees and agents to communicate with my child's prescribing physician, physician assistant, with prescriptive authority or advanced practice RN with prescriptive authority regarding my child's medication administration and/or medicating condition. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I further agree to indemnify and hold harmless the School District, its Board of Education, Board members, officers, employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of medication to my child.

_____ _____ Student Name: _____

Signature of Parent/Guardian Date

Parent/Guardian Printed Name: _____ School Name: _____

Address: _____

Home Phone Number: _____ Alternative Phone Number: _____

E-Mail Address: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

FOR PARENTS/GUARDIANS OF STUDENTS WHO NEED TO SELF-ADMINISTER MEDICATION REQUIRED UNDER A QUALIFYING PLAN:	**FOR PARENTS/GUARDIANS OF STUDENTS WHO NEED TO CARRY AND USE THEIR EPINEPHRINE, INSULIN OR ASTHMA MEDICATION:**
As indicated by my signature below, I grant permission for my child to self-administer his or her medication required under an asthma action plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form, a plan pursuant to Section 504 of the federal Rehabilitation Act of 1973, or a plan pursuant to the federal Individuals with Disabilities Education Act. 105 ILCS 5/10-22.21b. _____ Parent/Guardian Signature School Name: _____ Student Name: _____	As indicated by my signature below, I authorize VVSD 365 and its employees and agents, to allow my child to self-carry and self-administer their prescribed epinephrine, insulin, or asthma medication: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before/after normal school activities, such as while in before/after school care on school-operated property. I hereby verify that my health care provider has instructed my child in the proper self-administration of his or her medication. I agree to indemnify and hold harmless the School District, its Board of Education and Board members, and its officers, employees and agents from any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of allergy, asthma or diabetes medication to my child. I understand that the School District and its employees and agents shall incur no liability, except for willful and wanton conduct, related to the care of a student with diabetes or as a result of any injury arising from a student's self-carry and self-administration of an epinephrine injector or asthma medication. _____ Parent/Guardian Signature

**Please return your child's completed and signed form to the school nurse or building principal.