SACRED HEART SCHOOL
407 S. Henrietta St., Effingham, IL 62401
Fax: 217-342-9251 Phone: 217-342-4060

SCHOOL MEDICATION AUTHORIZATION FORM

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office, or in the absence of a school nurse, the Building Principal's office.

Student's Name:_____Birth Date:_____ Grade:_____ Teacher:_____
Address_____
Home Phone:_____Emergency Phone:_____

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

Physician's Printed Name:_____ Office Address:_____
Office Phone:_____ Emergency Phone:_____
Medication Name:_____ Purpose:_____
Dosage:_____ Frequency:_____
Time medication is to be administered or under what circumstances:_____
Prescription Date:_____Order Date:_____Discontinuation Date:_____
Diagnosis requiring medication:_____
Is it necessary for this medication to be administered during the school day? Yes No
Expected side effects, if any:_____
Time interval for re-evaluation:_____
Other medication student is receiving:_____

_____ _____
Physician Signature *Date*

For only parents/guardians of students who need to carry asthma medication or an EpiPen:

I authorize Sacred Heart School 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 Sacred Heart School 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).

*If you agree, please initial:*_____
Parent(s)/Guardian(s) Initial

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 authorize Sacred Heart School 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 Sacred Heart School), 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 Sacred Heart School and its employees 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.

_____ _____
Parent/Guardian Printed Name *Parent/Guardian Printed Name*

_____ _____
*Parent/Guardian Signature** *Date* *Parent/Guardian Signature** *Date*

**Both parents and/or guardians, if available, should sign.*

PLEASE CHECK TO INSURE FORM IS FILLED OUT COMPLETELY AND ACCURATELY.