Township High School District 211 Medication Authorization Form

Student's Name:_____ **ID #:**_____ **Date of Birth:** _____

The School Medication Authorization Form must be completed prior to medication administration in the school setting for prescription and/or over-the-counter medications, except that a separate authorization form is required for medical cannabis.
District 211 Board Policy J: Students Medication Administration in Schools

To be completed by the student's physician, physician assistant, or APRN with prescriptive authority:

Over-The-Counter Medication
Health Services has the following over-the-counter medications in stock: Ibuprofen (Advil), Acetaminophen (Tylenol), Diphenhydramine (Benadryl), and antacid. All other non-prescription medications must be brought to the Health Office by a parent/guardian in a manufacturer-labeled container. **Authorization for over-the-counter medication(s) by the parent/guardian and health care provider is valid until the student's graduation unless revoked in writing or otherwise specified below.**

I hereby authorize District 211 to administer the following medication(s) during school hours which include during school events:

- ☐ Ibuprofen/ Advil/ Motrin 1-2 tablets (200mg each) orally every 6 hours as needed.
- ☐ Acetaminophen/ Tylenol 1-2 tablets (325mg each) orally every 4 hours as needed.
- ☐ Diphenhydramine/ Benadryl 1-2 tablets (25 mg each) orally for acute allergic reaction.
- ☐ Antacid (2 tablets orally every 4 hours as needed).
- ☐ Other over-the-counter medication: _____Dosage: _____Frequency: _____

Time period or other limitation for this authorization (if none, write "N/A"): _____

Prescription Medication:
Prescription medications must be brought to the Health Office by the parent/guardian with the appropriate dosage, frequency, and name clearly visible on the pharmacy labeled container. **The medication authorization form must be renewed every year for prescription medications.**

Medication Name: _____Dosage: _____ Frequency: _____

Diagnosis requiring medication: _____Purpose: _____

It is necessary for this medication to be administered during the school day and/or school-related activities: □Yes □ No Time medication is to be administered or under what circumstances: _____

Expected side effects: _____

Other prescription medications the student is receiving/taking currently:_____

Authorization for self-carry and/or self-administration of epinephrine, insulin or other medication during a school field trip or overnight school trip (Not Required for Asthma Inhaler) not during the school day:

1) Do you authorize this student to self-carry the above medication? ☐Yes ☐No

2) Do you authorize this student to self-administer the above medication? ☐Yes ☐No

By checking yes to the above, I certify that the student has been instructed in the use of the above medication, understands the need for the medication, understands the need to report any unusual side effects to school personnel, and if authorized to self-administer the medication, is capable of administering it independently under the supervision of school personnel.

Prescriber Printed Name: _____

Office Address: _____

Office Phone #: _____ Office Fax #: _____

OFFICE STAMP

Prescriber Signature: _____Date _____

Rev. 3/13/23

Township High School District 211 Medication Authorization Form

To be completed by the Parent/Guardian:

By signing below, I, the parent/guardian of the above listed student, 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 medical emergency, I hereby authorize Township High District 211 and its employees and agents, on my behalf, to administer (or to allow my child to self-carry/self-administer medications pursuant to State law, while under the supervision of the employees and agents of Township High School District 211) lawfully prescribed medication in the manner described. This includes administration of undesignated epinephrine injectors, opioid antagonists, or asthma medication to my child when there is a good faith belief that my child is having an anaphylactic reaction, opioid overdose, or asthma episode, whether such reactions are known to me or not. 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, such as but not limited to athletic trainers during sports activities, school sponsors/chaperones during after school activities, off campus field trips, or overnight trips, and I, the parent/guardian, specifically consent to such practices. I agree to indemnify and hold harmless Township High School District 211 and its employees/agents against any claims arising out of the administration of medication to my child or my child's self-administration of medication.

Parent/Guardian Printed Name: _____**Date:** _____

Parent/Guardian Signature: _____ **Phone #:** _____

<u>Authorization for self-carry and/or self-administration of asthma inhaler, epinephrine, insulin or other medication required under a qualifying plan:</u>

I authorize the School District and its employees and agents, to allow my child to _____ self-carry and/or _____ self-administer **(please initial next to applicable authorizations)** his or her asthma medication, epinephrine injector, or any other medication as required under an Asthma Action Plan, a Diabetes Care Plan, an Individual Health Care Action Plan, an Illinois Food Allergy Emergency Action and Treatment Authorization Form, a Seizure Action Plan, a plan pursuant to Section 504 of the *Rehabilitation Act of 1973*, or a plan pursuant to the *Individuals with Disabilities Education Act*: (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 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-carry and self-administration of asthma medication, epinephrine injector or any other authorized medications.

Parent/Guardian Printed Name: _____**Date:** _____

Parent/Guardian Signature: _____ **Phone #:** _____