MORTON GROVE SCHOOL DISTRICT 70

CHALLENGING ★ GUIDING ★ INSPIRING

MEDICATION AUTHORIZATION FORM

STUDENT NAME_____BIRTHDATE _____WEIGHT_____

ADDRESS_____PHONE NUMBER_____GRADE _____

SCHOOL_____EMERGENCY CONTACT NAME/PHONE _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I, _____, parent/guardian of _____, am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Morton Grove School District 70 ("District") and its employees and agents, on my behalf and stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of the District, lawfully prescribed medication in the manner described below. I acknowledge that in order to authorize District personnel to administer over the counter medication, the District requires a prescription for that medication from an authorized physician or healthcare provider. All medication to be administered in the school must follow the attached *Park View School Medication Guidelines.*

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 will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage is changed. I understand that this medication authorization is only effective for the 2018-2019 school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the District, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

II. TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER FOR ALL MEDICATION
(Except for a Student Self-Administering Asthma Medication, see Section III below)

Diagnosis: _____ Name of Medication: _____

Dosage*: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered:_____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Special Instructions: (liquid, chewable, etc.): _____
_____

**For over the counter medication, if dosage is not specified above, child's weight will be used to determine proper dose.*

Self-Administration of Epinephrine: _____Yes _____No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: _____Yes _____No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number _____in the event of a reaction to the medication or an emergency

Licensed Prescriber Signature: _____ Date: _____

III. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY
TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage*: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered:_____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: _____Yes _____No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified healthcare professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PARK VIEW SCHOOL
MEDICATION GUIDELINES

If the child is required to receive any type of medication during school hours, only the school nurse, the principals, his/her designee or the student will administer the medication in compliance with the regulations as follows:

1. Written instructions from a physician will be required and will include:
    a. Child's name;
    b. Name of medication and dosage, whether prescription or nonprescription; and
    c. Frequency and time of administration.

2. All medication must be brought to school in a pharmacy container labeled with:
    a. Child's name;
    b. Prescription number;
    c. Medication name/dosage;
    d. Administration route and/or other directions;
    e. Date; and
    f. Physician's or licensed transcriber's name.

3. For Asthma inhalers, the original prescription label may be provided in lieu of a doctor's signed authorization. The label must contain the name of the medication, the dosage, and the time at which or circumstances under which he medication is o be administered.

4. Any change in dosage will require a physician's order. This may be sent in by fax to (847) 965-0606.

5. All of your child's over the counter medications also require a prescription from a licensed prescriber and are subject to the same District guidelines and policies for any other prescription medication. Therefore, over the counter medication must be noted in the Medication Authorization Form and are subject to the guidelines outlined herein.

6. The school nurse shall:
    a. Inform appropriate school personnel of the medication;
    b. Keep a record of the administration of the medication;
    c. Keep medication in a locked cabinet; and
    d. Returned unused medication to the parent.

7. Parent must complete and submit a signed Medication Authorization Form.

8. New forms are needed for each school year.

9. The school district retains the discretion to reject a request for the administration of any medication.

10. The school district and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or the use of epinephrine auto-injector by the pupil regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse