Sandwich CUSD #430 Medication Authorization Form

To Be Completed by Physician, P.A., Nurse Practitioner, or Dentist:

Student Name: DOB:	Date of Order:
Diagnosis requiring medication:	
Medication Required (Denote name, exact dosage, & route): Time to be given in school:	
Other medications student is taking that may interact with this medication:	
For Epi pens, inhalers, or insulin; will student self-administer this medication? Yes or No	
Is medication needed during school day for critical health & well-being of student? Yes or No	
****Illinois law (Public Act 99-0843) requests students with a diagnosis of asthma provide an Asthma Action Plan for school.****	
Physician Signature	

Print Physician Name:	Phone Number:
Address:	
City:	Zip:

To Be Completed by Parent or Legal Guardian:

By signing below, I agree:

1. 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 the School District& agents, in my behalf and stead, 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 of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and
2. To indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

_____ _____

Date Signature of parent /guardian