**KIRBY SCHOOL DISTRICT 140**
**Department of Special Services**
**708-532-8537**

# AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL
## Medical and Parental Authorization Form

The purpose of administering medications in school is to help each child maintain an optimal state of health that may enhance the child's educational plan. The medications shall be those required during school hours that are necessary to provide student access to the educational programs.

As the parent/guardian of the child listed, I am requesting that my child have the medication(s) as ordered by a licensed prescriber during school hours. I understand that all permission for long-term medication shall be renewed at least annually. Changes in medication will require written authorization from the licensed prescriber.
Prescription medication shall be in the original container and shall display the **5 Rights** of medication administration:

**Right child - Right medication - Right dosage - Right route - Right time of administration**

In addition, the original container shall display the licensed prescriber's name; pharmacy name, address and phone number; name or initials of pharmacist; prescription date and refill.
**All medications, including non-prescription medications,** shall be brought to school by the parent or responsible adult in a sealed container with the manufacturer's original label, listed ingredients and the child's name affixed to the container.

| **Date** | **Signature of Parent / Legal Guardian** |
|---|---|

## ********** REQUIRED INFORMATION**********

Child's Name: Date of Birth: School:

Parent(s) / Legal Guardian(s) Name(s):

Address:

City: State: Zip Code:

Home Telephone No. Work Telephone No. Cell Phone No.

Emergency Name: Telephone No.

**SELF-ADMINISTRATION OF ASTHMA and/or EPINEPHRINE AUTO-INJECTOR MEDICATION**

I hereby acknowledge that I am the parent and or legal guardian of the above referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize Kirby School District 140 to allow my child to possess and to self-administer his or her lawfully prescribed asthma medication or medication for a potential anaphylactic reaction during the following: (1) while in school; (2) while at a school-sponsored activity; (3) while under the supervision of school personnel; and (4) before or after normal school activities.

I further acknowledge and agree that the School district and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of asthma medication.

I further acknowledge and agree that, in absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless KSD 140 and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self-administration of said medication.

| **Date** | **Signature of Parent / Legal Guardian** |
|---|---|

***Instructions: Parent completes this side and licensed prescriber completes the reverse side.***

**KIRBY SCHOOL DISTRICT 140**
**Tinley Park, Illinois 60477**
**Department of Special Services**
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**School:** **Phone:** **Fax:**

**Child:** **Date of Birth:** **Allergies:**

## **********LICENSED PRESCRIBER ORDER**********

A written order for both prescription and non-prescription medications must be obtained from a licensed prescriber (physician, physician assistant, advanced practice nurse, dentist or podiatrist). This form is renewed yearly.

Date of Prescription Order for School Administration:

Name of Medication:

Dosage: Route: Time:

Diagnosis regarding medication:

Possible side effects of medication:

Other medications prescribed:

Time interval for re-evaluation of prescription:

**Signature of Licensed Prescriber** **Phone**

**If appropriate, please complete for child with asthma:**

Is the child able to self-possess and self-administer this medication? Yes / No

An Asthma Action Plan shall be completed yearly.

Comments:

**If appropriate, please complete for child who needs epinephrine auto-injector:**

Is the child able to self-possess and self-administer this medication? Yes / No

An Emergency Action Plan shall be completed yearly.

Comments:

***Instructions: Licensed prescriber completes this side and parent completes the reverse side.***