Laboratory Schools Medication Authorization Form

All prescription medications must be in the original pharmacy labeled container. Over the counter medication must be in the original container with the child's name affixed to the container. All medications (prescription and nonprescription) are generally required to be kept locked in the nurse's office or in the school office when not in use, unless the student has permission to self-administer the medication as outlined in this form. Unless ordered for a short term, all requests for self-administration of medication will expire at the end of the school year. If the parent/guardian does not pick up any unused medication after notification, the School Nurse shall dispose of the medication. No medication will be provided by the school.
All questions regarding medication administration may be directed to the Lab School District Nurse at 309-438-2435.

To be completed by the child's parent(s)/guardian(s).

Student's Name:_____Birth date:_____
School:_____Grade:_____Teacher:_____
Known Allergies:_____

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority.

Prescriber's Printed Name:_____
Office address:_____
Phone Number:_____
Medication name:_____
Purpose of Medication/Diagnosis:_____
Dosage:_____
Time of administration:_____
If medication is to be given "as needed", describe circumstances:_____
_____
How soon can it be repeated?_____
Is child authorized to medicate herself/himself?_____
Length of time this treatment is recommended:_____
List significant side effects:_____
Other Medication Student is receiving:_____
Is it necessary for this medication to be administered during the school day in order to allow the child to attend school or to address the student's medical condition that may arise at school?_____
Does medication qualify for an emergency action plan? Please provide a copy. (ie. Asthma Action plan, Food Allergy Action Plan, Seizure Action Plan, Diabetes Medical Management Plan)
_____
Date Signature of Physician, Physician Assistant, or Advanced Practice RN ONLY

For parents/guardians of students who need to carry asthma medication or an EpiPen:
I authorize the Laboratory school and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine injector while in school, while at a school-sponsored activity, while under the supervision of school personnel, or before or after normal school activities, such as while in before school or after school care on school operated property. Illinois law requires the Laboratory 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 results of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine injector. (105 ILCS 5/22-30).
Please initial to indicate authorization for your child to carry and use his or her asthma medication or epinephrine injector:_____

For parents/guardians of students who will self carry asthma medication please provide the prescription label of the medication.

It is the policy of the State of Illinois that the administration of medication to students during regular school hours and during school-related activities should be discouraged unless absolutely necessary for the critical health and well-being of the student. 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 the Laboratory Schools and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self administer pursuant to State law, while under the supervision of the employees and agents of the Laboratory Schools), lawfully prescribed medication in the manner described. 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 the Board of Trustees of Illinois State University on behalf of its Laboratory Schools and its employees and agents against any claims, except willful and wanton conduct, arising out of the administration or the child's self administration of medication. I further consent to the sharing of relevant medical information between the school and the physician's office.

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Date Parent/Guardian Signature Home phone Emergency phone