

KANELAND COMMUNITY UNIT SCHOOL DISTRICT #302

MEDICATION AUTHORIZATION FORM

For this student to receive medication during the school hours and on school grounds or for school-sponsored activities, this form must be fully completed by the prescribing physician and an authorizing parent or legal guardian.

STUDENT NAME: _____ BIRTHDATE: _____ GRADE: _____
 DATE OF THIS ORDER: _____ SCHOOL: _____ TEACHER: _____

Name of Drug	Dosage	Time To Be Given At School	Start date-End Date of Medication	Side Effects

____ I give permission to allow my child to carry and self-administer his or her asthma inhaler.
 ____ I give permission to allow my child to carry and self-administer his or her epinephrine auto-injector.
 Must this medication be administered during the day in order to allow the child to attend school or to address the student's condition? _____

 Signature of Health Care Provider Health Care Provider Phone Number Date

PARENT AUTHORIZATION

Asthma and Epinephrine Medication: I agree with the information provided above by my child's physician regarding asthma and epinephrine medication. I also give permission for my child to carry and to self-administer on an "as needed" basis asthma and/or epinephrine medication when my child is attending school, is under the supervision of school personnel, is at school-sponsored activities, or is on school property outside of regular school hours and regular school activities.

I herewith acknowledge 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 Kaneland School District and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described above. I further acknowledge and agree that I waive any claims I might have against Kaneland School District and its employees and agents arising out of the administration or attempted administration of medication to my child. I further agree to indemnify and hold harmless Kaneland School District and its employees and agents, either jointly or severally, against any claims arising out of the administration or attempted administration of medication to my child. If my child is authorized to self-administer asthma medication, I acknowledge and agree that Kaneland 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 by my child. I further agree to indemnify and hold harmless Kaneland School District and its employees and agents, either jointly or severally, against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

I give the school nurse permission to be in contact with the prescribing physician with regards to the above medication order and the response my child has to the prescribed medication.

 Parent's/Guardian Signature Phone Number Date

Kaneland John Stewart	630/365-0651 (FAX)	Kaneland McDole	630/897-3229 (FAX)
Kaneland John Shields	630/466-5320 (FAX)	Kaneland Middle School	630/466-4700 (FAX)
Kaneland Blackberry Creek	630/365-3905 (FAX)	Kaneland High School	630/365-5124 (Nurse FAX)