North DuPage Special Education Cooperative

Medication Authorization - The medication authorization form is valid for the current school year only.

To be filed at student's school building

Student's Name:				Birth Date:	
Address:					
Parent/Guardian Phone:			Emergency Phone:		
School:		Grade:		Teacher:	

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

Name of Medication:					
Dosage:		Frequency:		Time to be given in school:	
Date of prescription:		Date of order:		Discontinue/Re-evaluation Date:	
Purpose:				Time Interval for Re-evaluation:	
Diagnosis requiring medication:					
Intended effect of this medication:					
Expected side effects, if any:					
This medication must be administered during the school day in order to allow the child to attend school or to address the student's medical condition:				Yes ☐	No ☐
Epinephrine Auto-Injector Only: Student may carry and self-administer:				Yes ☐	No ☐
Other medications student is receiving:					
Prescriber's Signature:					
Prescriber's name (please print)					
Address:					
Office Phone:					
Emergency Phone:					
Date:					

Please attach sheet with further remarks.

I confirm 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 NDSEC and its employees and 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 and agents of NDSEC), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 90-480). **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**. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against NDSEC, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify NDSEC, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent(s)/Guardian(s) signature:	
Parent(s)/Guardian(s) name (please print):	
Address:	
Phone:	
Emergency Phone:	
Date:	

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Autorización de Medicamentos - El formulario de autorización de medicamentos es válido solamente para el año escolar actual.

Archivar en el edificio escolar del estudiante. (To be filed at student's building)

Nombre del estudiante:		Fecha de nacimiento:
Dirección:		
Teléfono del Padre/Madre/Guardián:	Teléfono de emergencia:	
Escuela:	Grado:	Maestro(a):

Esta sección debe ser completada por el médico del estudiante (To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority):

Name of Medication:			
Dosage:	Frequency:	Time to be given in school:	
Date of Prescription:	Date of Order:	Discontinue/Reevaluation Date:	
Purpose:		Time Interval for Re-evaluation:	
Diagnosis requiring medication:			
Intended effect of this medication:			
Expected side effects, if any:			
This medication must be administered during the school day in order to allow the child to attend school or to address the student's medical condition:		**Yes** ☐ **No** ☐	
Epinephrine Auto-Injector Only: Student may carry and self-administer:		**Yes** ☐ **No** ☐	

Other medications student is receiving:	
Prescriber's Signature:	
Prescriber's Name: (please print):	
Address:	
Office Phone:	
Emergency Phone:	
Date:	

Please attach sheet with further remarks. (Por favor use adjunte una hoja con más comentarios.)

Confirmo que soy la persona principal y responsable de administrar el medicamento a mi hijo(a). Sin embargo, en caso de que yo no pueda administrar el medicamento o en caso de una emergencia médica, por este medio autorizo a NDSEC y sus empleados y agentes, por mi parte y en vez de, administrar o intentar de administrar el medicamento a mi hijo(a) (o permitir a mi hijo(a) que se lo/la administre él/ella mismo(a), bajo la supervisión de los empleados y agentes de NDSEC), el medicamento legítimamente prescrito en la manera que se explica arriba. Esto incluye la administración de auto-inyectores de epinefrina no designadas a mi hijo(a) cuando existe la creencia de buena fe que mi hijo(a) está teniendo una reacción anafiláctica aunque tales reacciones son conocidas por mí o no (105 ILCS 5/22-30, modificado por P.A. 90-480). **Reconozco que puede ser necesario de administrarle el medicamento a mi hijo(a) a través de otra persona aparte de la enfermera escolar y específicamente doy mi consentimiento en tales practicas**. Además reconozco y estoy de acuerdo de, que cuando el medicamento prescrito legalmente es administrado o se intentó ser administrado, yo renuncio a cualquier demanda que yo pueda tener contra NDSEC, sus empleados y agentes que se presenten fuera de la administración del medicamento mencionado. También, estoy de acuerdo de en mantener indemne e indemnizar a NDSEC, empleados y agentes, ya sea colectivamente o respectivamente, de y contra cualquier y todos los reclamos, daños y, las causas por las acciones o heridas incurridas, cometidas o como resultado por la administración o el intento de administrar dicho medicamento.

(I confirm 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 NDSEC and its employees and 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 and agents of NDSEC), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 98-795). ***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.*** *I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the NDSEC, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the NDSEC, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.)*

Firma del Padre/Madre/Guardián *(Signature)*:	
Nombre del Padre/Madre/Guardián (letra de molde) *(Name):*	
Dirección *(Address)*:	
Teléfono *(Phone)*:	
Teléfono en caso de emergencia *(Emergency Phone)*:	
Fecha *(Date)*:	