Heyworth CUSD #4 School Medication Authorization Form

☐Heyworth Elementary
100 S. Joselyn Street
Heyworth, IL 61745
Ph# 309-473-2822
Fax # 309-473-9013

☐Heyworth Jr/Sr High
308 W. Cleveland
Heyworth, IL 61745
Ph# 309-473-2322
Fax # 309-473-2323

Student's Name:	Date of Birth:
Address:	Home Phone #
	Emergency Ph #
Grade: Homeroom:	
Known Allergies:	

To be completed by the physician: **To be renewed for each school year

Medication:	
Dosage:	Route:
Time medication is to be administered and under what circumstances:	
**Prescription start date:	**Discontinuation date:
Diagnosis requiring medication:	
Intended effect of this medication:	
Expected side effects, if any:	
Is it necessary that this medication be administered during the school day in order for the child to attend school or to address the child's medical condition? ☐ Yes ☐ No	
Other medications student is receiving:	
Can student self-administer this medication? (inhalers and insulin only) ☐ Yes ☐ No	

Office address:_____ Office Ph #: _____

_____ Emergency Ph#:_____

_____ _____ _____
Physician's signature Date Physician's printed name

For the parent/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 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 the school district), lawfully prescribed medications in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other that the 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.

_____ _____ _____
Parent/Guardian signature Date Parent/Guardian printed name

_____ _____ _____
*Parent/Guardian signature Date Parent/Guardian printed name

*Both parents and or guardians, if available, should sign.

Heyworth CUSD #4 School Medication Authorization Form
For Asthma Medication Self-administration Only
(to be completed **in addition** to all of page 1)

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Student's Name:	Date of Birth:
Address:	Home Phone #:
	Emergency Ph #:
Grade: Homeroom:	
Medication:	

By signing below, I agree:

I authorize the school district and its employees and agents, to allow my child or ward to possess and use his or her asthma medication (1) while in school, (2) while at a school—sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the school district to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

_____ _____ _____
Parent/Guardian signature Date Parent/Guardian printed name

_____ _____ _____
*Parent/Guardian signature Date Parent/Guardian printed name
*Both parents and or guardians, if available, should sign.

Board Policy Reference 720.034, version: 8/1/2008