Koraes Elementary School
School Medication Authorization Form

To be completed by the student's parent(s) / guardian(s) / and physician and kept in the school's office.

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

Student's Name: _____ Birth Date: _____
Address: _____
Home Phone: _____
Emergency Phone: _____
Grade: _____
Teacher: _____

To be completed by the child's physician:

Physician's Printed Name: _____
Office Address: _____
Office Phone: _____
Emergency Phone: _____
Medication: _____
Dosage/Route: _____
Frequency: _____ Time: _____

For Asthma Medication and/or Epinephrine Auto-Injector Only:

I certify that _____has been instructed in the use and self-administration of _____. He/she understands the need for the asthma medication and/or epinephrine auto-injector, and the necessity to report to school personnel any unusual side effects. He/she is capable of using the asthma medication and/or an epinephrine auto-injector independently.

Diagnosis requiring medication: _____
Intended effect of this medication: _____

Must this medication 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 _____

Expected side effects, if any: _____
Time interval for re-evaluation: _____
Discontinuation Date: _____
Other medications student is receiving: _____

Physician's Signature _____ **Date** _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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

For parent(s)/guardian(s) of students who have asthma and/or are at risk of anaphylaxis:
I authorize Koraes Elementary School and its employees and agents, to allow my child or ward to possess and use his/her asthma medication and/or epinephrine auto-injector (1) while in school, (2) while at a school sponsored activity, (3) while under 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 Koraes Elementary School to inform parent(s)/guardian(s) that 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 (105ILCS 5/22-30).

_____ _____
Parents(s)/Guardian(s) Signature Date

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

By signing below:

1. I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Koraes Elementary School and its employees, agents, and employees who volunteer to do so, in my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer, while under the supervision of Koraes Elementary School employees, agents, and employees who volunteer to provide such supervision), lawfully prescribed medication in the manner described above. 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 Koraes Elementary School, its employees, agents, and employees who volunteer as set forth above arising out of the administration or attempted administration of said medication. In addition, I agree to save, defend, hold harmless and indemnify Koraes Elementary School, its employees, agents, and employees who volunteer as set forth above 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.

2. I agree to save, defend, indemnify and hold harmless Koraes Elementary School and its employees, agents, and employees who volunteer as set forth above against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

_____ _____
Parent/Guardian Printed Name *Parent/Guardian Printed Name*

_____ _____
*Parent/Guardian Signature ** *Parent/Guardian Signature **

Date _____ Date _____

****If available, both parents/guardians should sign.***

The School Medication Authorization Form expires at the end of the school year.

PLEASE COMPLETE BOTH SIDES OF THIS FORM