RIVER FOREST PUBLIC SCHOOLS – www.district90.org

Administration Building - 7776 Lake Street, River Forest, IL 60305 - 708·771·8282 /Fax 708·771·8291

SCHOOL MEDICATION AUTHORIZATION FORM for 2024-2025 school year

Student Name:_____ Birthdate_____ Age____ Sex_____

School_____ Grade Level_____

PHYSICIAN'S ORDER: (needed for prescription and/or over-the-counter medicine)

Medication #1_____ Dosage_____

Time to be given/Instructions_____ Route_____ Starting Date_____

Diagnosis/Reason for medication_____

Procedure if dosage is missed_____

Possible side-effects_____

Medication #2_____ Dosage_____

Time to be given/Instructions_____ Route_____ Starting Date_____

Diagnosis/Reason for medication_____

Procedure if dosage is missed_____

Possible side-effects_____

Other Medications student is receiving_____

Asthma or Allergy Medication Only: ☐ ASTHMA Inhaler ☐ Epi-Pen

☐Yes ☐No Student may carry medication on his/her person

☐Yes ☐No Student may self-administer medication. Directions for self-administration:

Physician's Name (Print)_____ Address or Office Stamp:

Physician's Signature _____

Date_____ Phone_____

PARENT/LEGAL GUARDIAN AUTHORIZATION:

I give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by a pharmacy. If it is over-the-counter, it will be sent in the original package with my child's name on it. I will notify the school in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication order is changed.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature_____ Date _____

Daytime contact numbers: Cell_____ Work_____ Home _____

OVER > > > for Parent/Guardian Agreement Authorizing Self-Administration of Asthma Medication or Epi-Pen

--- *Additional Parent/Guardian Signature required on back* --- **OVER** > > >

Agreement Authorizing Self-Administration of Asthma Medication or Epi-Pen

I/We,_____, the parent(s) or

legal guardian(s) of_____, a student at River Forest School District 90, hereby authorize my/our child to self-administer:

_____Asthma Medication
_____Epi-Pen

while at school and have provided a physician's statement in compliance with State statute. I/We have instructed my/our child not to share his/her medication with any other student. Additionally, I/We understand that according to State statute, the School District and its employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of the:

_____Asthma Medication
_____Epi-Pen

by my/our child. I/We further understand and agree that as the parent(s) or legal guardian(s) of my/our child, I/we must 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:

_____Asthma Medication
_____Epi-Pen

by my/our child. I/We further understand that this permission for self-administration of:

_____Asthma Medication
_____Epi-Pen

is effective for this school year only, and must be renewed each subsequent school year, if desired. I/We understand that a copy of this permission will be kept in my/our child's medical file.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature_____Date _____

Daytime contact numbers:

Cell_____Work_____Home _____