Rankin School District #98 ***2024-2025 School Year***

PRESCRIPTION MEDICATION AUTHORIZATION FORM

This form is only good for ONE school year.

Student's Name:_____ D.O.B. _____ Grade: _____

This form must be signed by your PHYSICIAN for all PRESCRIPTION medications to be given at school.

Name of Medication: _____

Purpose/Diagnosis requiring medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances: _____

Prescription date: _____ Order date: _____ Discontinuation date: _____

If INHALER is prescribed, is it to be carried on the person ____ or can it be stored in the office ____ (check one)

Expected side effects, if any: _____ Time interval for re-evaluation: _____

Other medications student is receiving: _____

Physician's Signature: _____ Physician's Name (please print): _____

Physician's Address: _____

Physician's Phone: _____ Physician's Emergency Phone: _____ Date: _____

Asthma Inhalers: (Attach prescription label below)

For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:

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 and 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 or epinephrine auto-injector (105 IL CS 5/22-30).

If you agree, please initial _____
Parent/Guardian

By signing below, I agree:

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 Rankin School District No. 98 and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of Rankin School District No. 98), lawfully prescribed medication 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 than a school nurse, and specifically consent to such practices,** and I agree to indemnify and hold harmless Rankin School District No. 98 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian printed name: _____ **Signature:** _____ **Date:** _____