

Freeburg Community Consolidated School District No. 70

408 SOUTH BELLEVILLE STREET – FREEBURG, IL 62243
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SUPERINTENDENT
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STUDENT MEDICATION AUTHORIZATION FORM

***To Be Completed by the Student's Parent(s)/Guardian(s).
A New Form Must Be Completed Every School Year for Each Medication.***

Student's Name: _____ Birth Date: _____

Address: _____

School: _____ Grade: _____ Teacher: _____

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 Freeburg Community Consolidated School District No. 70 and its employees and agents, on my behalf, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described below. 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 the School District 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

Address (if different from Student's above)

Home Phone

Cell Phone

Emergency Phone

Parent/Guardian Signature

Date

To Be Completed by the Student's Healthcare Provider For All Prescription and Non-Prescription Medications:

Prescriber's Printed Name

Office Address

Office Phone *Emergency Phone*

Medication Name

Dosage *Frequency*

Time Medication is to be Administered or Under What Circumstances

Prescription Date *Order Date* *Discontinuation Date*

Expected Side Effects, if any

Other Medications Student is Receiving

Prescriber's Signature

Date

For Parent(s)/Guardian(s) of Students Needing Self-Administration of Prescribed Asthma Medication:

Is the asthma medication required under a student's Individual Health Care Action Plan, Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form, or pursuant to Section 504 of the federal Rehabilitation Act of 1973?

Yes No

For asthma medication, attach the prescription label with the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer 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.

Freeburg Consolidated School District No. 70, and its employees and agents, either jointly or severally, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication regardless of whether authorization was given by the student's parents/guardians, or the student's physician, physician's assistant, or advanced practice registered nurse. By signing the below, you are releasing Freeburg Community Consolidated School District No. 70 from liability and holding it harmless against any claims, except for those based on willful and wanton conduct, arising out of the self-administration of medication.

Parent/Guardian Signature

Date

For Parent(s)/Guardian(s) of Students Needing Self-Administration of Epinephrine Auto Injectors:

Is the epinephrine injector required under a student's Individual Health Care Action Plan, Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form, or pursuant to Section 504 of the federal Rehabilitation Act of 1973?

Yes No

For an epinephrine injector, attach a written statement from the student's physician, physician assistant, or advanced practice registered nurse containing the following: name and purpose of the epinephrine, injector; the prescribed dosage; and the time or times at which or the special circumstances that the epinephrine injector should be administered.

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her epinephrine auto injector: (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.

Freeburg Consolidated School District No. 70, and its employees and agents, either jointly or severally, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of an epinephrine auto injector regardless of whether authorization was given by the student's parents/guardians, or the student's physician, physician's assistant, or advanced practice registered nurse. By signing the below, you are releasing Freeburg Community Consolidated School District No. 70 from liability and holding it harmless against any claims, except for those based on willful and wanton conduct, arising out of the self-administration of medication.

Parent/Guardian Signature

Date