Trinity Student Medication-ALL medication including over the counter Physician/Parental Authorization

To be completed by the child's parent(s)/guardian(s). *A new form must be completed every school year. Keep in the school office with copies given to the appropriate people (i.e. teachers, Extended Care, etc.).*

Student's Name: _____ Birth Date: ____-____-_____

Home Address: _____City, State, Zip_____

Home Phone:_____ Emergency Phone:_____

T*o be completed by the student's physician, physician assistant, or advanced practice RN:*

Physician's Printed Name:_____

Address:_____

Office Phone: _____Emergency Phone:_____

Medication name: _____

Purpose: _____

Diagnosis requiring medication: _____

Dosage:_____ Frequency: _____

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

_____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

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: _____

Other medications student is receiving: _____

_____

Physician's Signature: _____ **Date:** _____

For all Parents/Guardians:

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 the Trinity Lutheran School and its employees and agents, in my behalf, to administer or to 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 Trinity Lutheran), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **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 Trinity Lutheran School 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 Signature Date

_____

Parent/Guardian Printed Name

Contact Phone Number_____

Home Address (if different from student)_____

_____

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

I authorize Trinity Lutheran and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use 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. Illinois law requires the school 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 ILCS 5/22-30).

Please initial below to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

_____ _____

Parent/Guardian Signature Date