TMCSEA
SCHRAMM EDUCATIONAL CENTER

SCHOOL MEDICATION AUTHORIZATION FORM
ADMINSTRATION OF HEALTHCARE SERVICES AND/OR TREATMENTS

Student's Name (Last) (First) (Middle)	Date of Birth	Home District	Date
_____	___/___/___	_____	_____

School medications and health care services are administered following these guidelines:

Physician/Prescriber signed dated authorization to administer the medication/treatment.
Parent signed, dated authorization to administer the medication/treatment.
The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
The medication label contains the student's name, name of the medication, directions for use and date.
Annual renewal of authorization and immediate notification, in writing, of changes.

Physician Authorization:

1.

Name of Medication	Dosage	Route of Administration	Time to be Administered at School
Administration Instruction	Intended Effect	Expected Side Effects if Any	Diagnosis Requiring Medication

2.

Name of Medication	Dosage	Route of Administration	Time to be Administered at School
Administration Instruction	Intended Effect	Expected Side Effects if Any	Diagnosis Requiring Medication

3.

Name of Medication	Dosage	Route of Administration	Time to be Administered at School
Administration Instruction	Intended Effect	Expected Side Effects if Any	Diagnosis Requiring Medication

4.

Name of Medication	Dosage	Route of Administration	Time to be Administered at School
Administration Instruction	Intended Effect	Expected Side Effects if Any	Diagnosis Requiring Medication

Other medications student is taking:_____

_____

_____ _____
Prescriber's Signature Date Signed

_____ _____
Prescriber's Emergency Phone # Prescriber's Address

I HEREBY GIVE PERMISSION FOR THE SCHOOL NURSE TO ADMINISTER MEDICATION TO BE TAKEN DURING THE SCHOOL DAY, AS PRESCRIBED BY MY PHYSICIAN.

I acknowledge that it may be necessary for the administration of medications and treatments to my child, be performed by an individual other than a school nurse, and specifically consent to such practices. 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 the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify TMCSEA, its employees and agents, 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. I authorize the school to fax this completed authorization to my child's healthcare provider for his/her signature and I authorize that provider to fax this information back to the school.

_____ _____
Parent/Guardian Signature Home Phone

_____ _____
Parent/Guardian Address Business Phone

_____

_____
Date

For parent(s)/guardian(s) of students who have asthma:

I authorize TMCSEA 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 or 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 (105 ILCS 5/22-30).

If you agree please initial: _____
Parent(s)/Guardian(s) initials