

## LaSalle-Peru Township High School

### Student Medication Authorization Form

*To be completed by the child's parent(s)/guardian(s). This form is to be used for medication other than medical cannabis. For a medical cannabis authorization contact the building principal. A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.*

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

*To be completed by the student's physician, physician assistant with prescriptive authority or advanced practice RN with prescriptive authority (**Note:** for asthma inhalers only, use the **Asthma Inhalers** section below):*

Prescriber's Printed Name: \_\_\_\_\_  
Office Address: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
Medication name: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Time medication is to be administered or under what circumstances:  
\_\_\_\_\_

Prescription date: \_\_\_\_\_ Order date: \_\_\_\_\_ Discontinuation date: \_\_\_\_\_  
Diagnosis requiring medication: \_\_\_\_\_  
Is it necessary for this medication to be administered during the school day?      Yes      No  
Expected side effects, if any: \_\_\_\_\_  
Time interval for re-evaluation: \_\_\_\_\_  
Other medications student is receiving: \_\_\_\_\_

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date

#### Asthma Inhalers

*Parent(s)/Guardian(s) please attach prescription label here:*

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

I authorize LaSalle-Peru Township High School 120, hereafter LPHS and its employees and agents, to allow my child self-carry and self-administer his or her asthma medication and/or epinephrine 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 LPHS 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-carry and self-administration of asthma medication or epinephrine auto-injector. 105 ILCS 5/22-30.

**Please initial 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 Initials

**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 LPHS and its employees and agents, on 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 LPHS), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors or opioid antagonist to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, 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 LPHS 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 the Student's above): \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date