Scott-Morgan Community Unit School District #2
100 West Rockwood Street
Bluffs, Illinois 62621-0230
Phone: 217-754-3815 FAX:217-754-3275
Kevin Blankenship, Superintendent Spencer Range, Principal

School Medication Authorization Form

To be completed by the child's parent/guardian. A new form must be completed every school year. Please complete one form per medication. Medication must be brought to the office in the original container.

Student's name: __________________________________ Birth Date: ______________

Address: ____

Home phone: ___________________ Cell phone: ________________

To be completed by the student's physician.

Physician's printed name: ____

Office address & phone: ____

Medication name: ____

Purpose of medication: ____

Dosage: ______________________________________ Frequency: ________________

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

Prescription date: _______ Order date: __________ Discontinuation date: ___________

Diagnosis requiring medication: ____

Expected side effects, if any: ____

Other medications student is receiving: _______________________________________

____
Physician's signature Date

(Parent's must complete back of form)

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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 Bluffs School 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, while under the supervision of the employees and agents of Bluffs School), lawfully prescribed medication in the manner described above, or over the counter medication that has been brought in by the student in the manner indicated on the container.

I acknowledge that Bluffs School does not have a school nurse. I agree to indemnify and hold harmless Bluffs 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.

If you agree, please initial: ________________ Parent/guardian

For only parents/guardians of students who need to carry asthma medication or an EpiPen®:

I authorize Bluffs School and its employees and agents, to allow my child or ward to possess and use his/her asthma medication and/or epinephrine auto-injector while in school. Illinois law requires Bluffs School to inform parents/guardians 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).

If you agree, please initial: ________________ Parent/guardian

____ ______________________________

Parent/Guardian printed name Parent/Guardian printed name

___________________________ ____

Parent/Guardian signature Parent/Guardian signature

Both parents and/or guardians, if available, should sign.