

**MAINE EAST HIGH SCHOOL – DISTRICT 207  
MEDICATION AUTHORIZATION FORM**

DATE \_\_\_\_\_

STUDENT'S  
NAME \_\_\_\_\_ ID \_\_\_\_\_ DOB \_\_\_\_\_

PARENT'S EMERGENCY PHONE NUMBER \_\_\_\_\_

**FOR THE HEALTH CARE PROVIDER**

*This Section must be completed and signed by either: (i) the student's physician; (ii) physician assistant; or (iii) advanced practice registered nurse:*

DIAGNOSIS \_\_\_\_\_

NAME OF MEDICATION TO BE GIVEN: \_\_\_\_\_

Must this medication be administered during the school day in order to allow the child to attend school? \_\_\_ YES \_\_\_ NO

DOSAGE AND ROUTE OF ADMINISTRATION \_\_\_\_\_

TIME AND CIRCUMSTANCES OF ADMINISTRATION AT SCHOOL: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

POSSIBLE SIDE EFFECTS: \_\_\_\_\_

\_\_\_\_\_

OTHER MEDICATIONS CHILD IS RECEIVING: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, Physician's Assistant, or Advanced Practice Registered Nurse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Health Care Provider

\_\_\_\_\_  
Phone #

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

(Parent must complete the reverse side)

**FOR THE PARENT**

*This Section must be completed by the student's parent or guardian:*

Pursuant to the authority granted under Section 105 ILCS 5/22-30 of the Illinois School Code, I hereby authorize my son/daughter, \_\_\_\_\_, to receive/self-administer the referenced medication at school, school-sponsored activities, while under the supervision of school personnel, and before/after normal school activities such as before/after school care on school operated property.

I agree to indemnify and hold harmless the School District, its Board of Education and the Board's members, officers, employees and volunteers from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnities and arising out of a claim related directly or indirectly to my son/daughter's receipt/self-administration of the above referenced medication of and brought by me, any other parent or guardian of my student or another student, or by or on behalf of my student or another student. We understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the administration/self-administration of medication, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnities.

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

\_\_\_\_\_  
Date

This form shall be effective for the 20\_\_ - 20\_\_ school year only, and must be renewed each subsequent school year.

Date Medication Form received at school: \_\_\_\_\_ Nurse Signature \_\_\_\_\_