MEDICATION AUTHORIZATION FORM

This form must be completed in its entirety or medication will not be administered at school. A physician's authorization is required for all medication administered during the school day, including over-the-counter medication.

PHYSICIAN

Prescription and non-prescription medication during school hours should be limited to what is absolutely necessary for a child to attend school.

Student/Participant Name: _____ Date of Birth: _____

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency: ☐ Scheduled ☐ PRN **Time to be administered:** _____

Indication: _____

Side effects: _____

Order valid for: ☐ Current school year, including Extended School Year

☐ Other (specify):

Administration instructions: _____

For Asthma Medications/Epinephrine Auto-Injectors Only:

Is self-carry of asthma medication authorized?	☐ Yes	☐ No
Is unsupervised self-administration of asthma medication authorized?	☐ Yes	☐ No
Is self-carry of epinephrine auto-injector authorized?	☐ Yes	☐ No
Is unsupervised self-administration of epinephrine auto-injector authorized?	☐ Yes	☐ No

Physician's Authorization – For ALL Medications

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Phone: _____

Physician's Address: _____

PARENT

PLEASE BE SURE THE FOLLOWING STEPS HAVE BEEN TAKEN:

- All medication must be in the original container and clearly labeled.
- Most pharmacies will provide a labeled bottle for school use upon request.
- For asthma medication, parent/guardian must attach prescription label to this form.
- Prescription medication label must indicate:
  - Your child's name
  - The name of the medication
  - The correct dosage, and
  - The current date

For Asthma/Epinephrine Auto-Injectors Only (initial all that apply)

_____ I consent to my student's/participant's self-carry of asthma medication.

_____ I consent to my student's/participant's self-carry and unsupervised administration of asthma medication

_____ I consent to my student's/participant's self-carry of an epinephrine auto-injector.

_____ I consent to my student's/participant's self-carry and unsupervised administration of an epinephrine auto-injector

Questions? Call (630) 864-3800. Please fax completed forms to (630) 864-3820.

PARENT/GUARDIAN CONSENT CONTINUED ON NEXT PAGE.

This form is incomplete if parent/guardian consent not provided. Without a completed form, medication will **NOT** be administered.

PARENT

Parent/Guardian Acknowledgement and Consent

I hereby acknowledge 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 request and authorize Giant Steps and its employees and agendas, on my behalf, to administer or attempt to administer to my child, or allow my child to self-administer if authorized, the lawfully prescribed medication in accordance with the instructions provided by the physician on this authorization form. I understand my child may be administered an undesignated epinephrine auto-injector when school personnel have a good faith belief that my child is having an anaphylactic reaction, whether such reaction is known to me or not. I further acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices. In addition, I give permission for school staff to contact my child's doctor regarding administration and effects of the medication ordered. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

I waive any claims against Giant Steps, its employees, and its agents arising out of the administration, and agree to hold harmless and indemnify Giant Steps, its employees, and its agents, either jointly or separately, from and against any and all claims, demands, damages, causes of action, or injuries, costs, and expenses including attorney's fees, incurred or resulting from the negligent administration, attempted administration, or self-administration of medication(s). With respect to the administration of asthma medication or an epinephrine auto-injector (whether designated or undesignated) regardless of whether authorization was given by me or by my child's physician this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

Parent/Guardian's Signature: _____ Date: _____