



SPECIAL EDUCATION ASSOCIATION OF PEORIA COUNTY

4812 W. Pfeiffer Rd., Bartonville, IL 61607

PH: 309-697-0880 Fax: 309-697-0884

Student's Name:	DOB:	SIS:	Grade:	Location:
-----------------	------	------	--------	-----------

Physician Authorization for Administering Medication at School

To be completed by the student's Physician or authorized prescriber

Name of Medication:
Dosage/Route/Time:
Effective Dates (limited to one school year) From/To:
Diagnosis/Reason for Medication:
Possible Side Effects:

Physician Signature:	Date:
Physician's Printed Name/Address:	
Phone #/Fax#	Emergency Number:

PARENT/GUARDIAN AUTHORIZATION FOR STUDENT TO SELF-ADMINISTER MEDICATION

For parents/Guardians of students who need to carry medications for Life Threatening Emergencies (Inhaler/Epi-Pen):

I authorize the school district and its employees/agents to allow my child or ward to carry and self-administer his/her inhaler and/or Epi-Pen auto-injector while in school, while at a school-sponsored activity, while under the supervision of school personnel, before or after normal school activities, such as while in before or after school care on school-operated property. Illinois law requires the School District to inform parent/guardian 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. **If you agree, please initial here:** _____

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 the School District and its employees/agents, on my behalf, to administer or attempt to administer to my child, lawfully prescribed medication in the manner described above.

I acknowledge that it may be necessary for the administration of medication to my child to be performed by someone other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District members of the Board of Education, its employees/agents against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the administration of medication or storage of any medication by school personnel.

Parent/Guardian
Signature: _____

DATE: _____

