January 2022

Handbook for School Administrators

MEDICATION AUTHORIZATION FORM

To be updated by parent/guardian/physician annually

Physician's Order

Student_____Grade_____

_____

Medication/Health Care Treatment Dosage Time(s) to be administered

_____

Intended effect of this medication Expected side effects, if any

_____

List any other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**
   (Please circle) YES NO

2) **For ALLERGY CONDITIONS ONLY;**
   I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision. I have reviewed and signed the student's Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form, if the nature of the student's allergies requires.

   (Please circle) YES NO

3) **I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.**

   (Please circle) YES NO

4) **For ASTHMA MEDICATIONS ONLY: I have assisted in the development of an Asthma Action Plan to help control the student's asthma as needed. I have ensured that the student has been instructed in the use and self-administration of asthma medication and is capable of self-administering asthma medication independently and without supervision.**

   (Please circle) YES NO

5) **FOR DIABETES MEDICATIONS ONLY: I have provided instructions concerning the student's diabetes management during the school day, and any other information necessary to complete a diabetes care plan, including a copy of the signed prescription, methods of insulin administration, and a uniform record of glucometer readings.**

   (Please circle) YES NO

Administration Instructions:

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Discontinue Re-evaluation Follow-up (Please Circle): _____
Date

_____	_____
Physician's /Prescriber's Signature	Date Signed
_____	_____
Physician's/ Prescriber's Name (PRINT)	Emergency telephone number
_____	_____
Address	City, State, Zip Code

Medication Authorization approved or denied and signed this_____day of_____, 20_____,

By_____on behalf of St. Emily School, Mount Prospect, Illinois

Signature of Principal / designee
