THE UNIVERSITY OF CHICAGO | LABORATORY SCHOOLS

Prescription Medication Authorization Form

Student's Name _____

Grade _____ **Birthdate** _____ /_____ /_____ (mm/dd/yyyy)

Medication Allergy _____

Healthcare Provider please fill in:

For Asthma

Medication Name _____ **Dosage** _____

Route _____ **Time to be administered** _____

Condition Requiring Medication _____

Possible side effect(s) _____

Is the student reliable to carry his/her own inhaler and self-medicate?

☐ **YES.** The student named above has been instructed on the proper technique for using an inhaler and spacer and knows the proper dosage and frequency of the medication; s/he is reliable to self-medicate and has permission to carry and self-administer inhaled asthma medication.

☐ **NO.** The student named above is not yet able to self-medicate and will report to the Nurse's Office for any inhaled medications.

For Allergic Reactions

Medication Name _____ **Dosage** _____

Route _____ **Time to be administered** _____

Condition Requiring Medication _____

Possible side effect(s) _____

Is the student reliable to carry his/her own EpiPen and self-medicate?

☐ **YES.** The student named above has been instructed on the proper technique for using an EpiPen and knows the proper dosage and frequency of the medication; s/he is reliable to self-medicate and has permission to carry and self-administer epinephrine injection.

☐ **NO.** The student named above is not yet able to self-medicate and will report to the Nurse's Office for any administration of epinephrine injection.

Other

Medication Name _____ **Dosage** _____

Route _____ **Time to be administered** _____

Condition Requiring Medication _____

Possible side effect(s) _____

Patient's status and medication are assessed every _____ **months.**

Healthcare Provider's Name _____

Healthcare Provider's Signature _____

Phone _____ **Date** _____ /_____ /_____ (mm/dd/yyyy)

The student's parent(s) or guardian(s) must complete this section: Pursuant to the authority granted Section 105 ILCS 5/22-30 of the Illinois School Code, **I hereby authorize my son/daughter** _____ to carry and self-administer the above referenced medication (1) while in school, (2) while at school sponsored activities, (3) while under the supervision of school personnel, or (4) before/after normal school activities such as before/after school care on school-operated property. I agree, and have explained to my child, the importance of reporting to school staff the self-administration of this medication while in school. I agree to indemnify and hold harmless University of Chicago Laboratory Schools and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the student's self-administration of medication.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____ /_____ /_____ (mm/dd/yyyy)

Please upload your completed, signed form to XXXXXXXXX

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