

**Altamont Lutheran Interparish School  
School Medication Authorization Form**

To be completed by the child's parent(s)/guardian(s) and kept in the Principal's office before medication is used at school:

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

To be completed by the student's physician:

Physician's Printed Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Medication: \_\_\_\_\_

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Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time medication is to be administered or under what circumstances:

Prescription date: \_\_\_\_\_ Order date: \_\_\_\_\_ Discontinue date: \_\_\_\_\_

Diagnosis requiring medication: \_\_\_\_\_

Intended effect of this medication: \_\_\_\_\_

Must this medication be administered during the school day to allow the child to attend school or to address the student's medical condition? \_\_\_\_ Yes \_\_\_\_ No

Expected side effects, if any: \_\_\_\_\_

Time interval for re-evaluation: \_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For parent(s)/guardian(s) of students who have asthma:**

I authorize ALIS and its employees and agents, to allow my child or ward to possess and use his/her asthma medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires ALIS to inform parent(s)/guardian(s) 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 (105 ILCS 5/22-30).

**If you agree please sign:** \_\_\_\_\_

**For All Medications: By signing below, I agree:**

1. 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 ALIS and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of ALIS), lawfully prescribed medication in the manner described on the other side. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices,** and
2. To indemnify and hold harmless ALIS and its employees and agents against any claims, except a claim based on willful and wanton conduct arising from the administration or attempt at administration of these treatments, or the self-administration of these treatments by the pupil.
3. I give the school personnel, including the School Health Nurse, permission to contact the

Physician \_\_\_\_\_ ordering these treatments for my child.  
Physician's name

\_\_\_\_\_  
Parent/Guardian printed name

\_\_\_\_\_  
Parent/Guardian printed name

\_\_\_\_\_  
Parent/Guardian signature \*

\_\_\_\_\_  
Parent/Guardian signature \*

\* Both parents/guardians, if available, should sign.