

**Mokena Public Schools District 159  
Asthma Medication Authorization Form for 2009/2010 School Year**

Students Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

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

**To be completed by the student's physician:**

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time to be given at school: \_\_\_\_\_

Date Prescription to Start: \_\_\_\_\_ Discontinuance Date: \_\_\_\_\_

Diagnosis Requiring Medication: \_\_\_\_\_

Desired benefits of this Medication: \_\_\_\_\_

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

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

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? (circle and initial) yes \_\_\_\_\_ no \_\_\_\_\_

May this medication be safely administered by school personnel other than the school nurse?  
(circle and initial) yes \_\_\_\_\_ no \_\_\_\_\_

**Physician Authorization for Self-Administration of Asthma Medication**

In compliance with Senate Bill 0979 (August 17, 2001), I have instructed this student in proper use and authorize him/her to carry and self-administer the above mentioned asthma medication. (circle and initial) yes \_\_\_\_\_ no \_\_\_\_\_  
**(Attach Authorizing Agreement for Self-Administration of Asthma Medication Form)**

\_\_\_\_\_  
Physician's Name (please print)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Street/City Address

\_\_\_\_\_  
Office Phone/ Emergency Phone

I hereby confirm 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 Mokena Public Schools District 159 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 the Mokena Public School District), lawfully prescribed medication in the manner described above. 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. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Emergency Phone Number