☐ **Main Office**
☐ **School Nurse**
☐ **Athletic Department**

Salem Community High School District #600 Adapted from 7:300-E3

Medical Treatment & School Medication Authorization

(IN CASE OF EMERGENCY THIS FORM ACCOMPANIES STUDENT TO THE HOSPITAL)

TO BE COMPLETED BY THE CHILD'S PARENT(S)/GUARDIAN(S). A NEW FORM MUST BE COMPLETED EVERY SCHOOL YEAR.

Student's Name:_____ Birth Date: _____ Grad Year: _____

Parent/Guardian Name:_____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact:_____ Emergency Phone: _____

Physician's Name: _____ Office Phone: _____

Medical Insurance Company Name or State Medical Card: _____

Insured Name: _____ Relationship to Student: _____

Policy Number: _____ Group Number: _____

Please provide the following student medical information:

1. Does the student have any food, insect, or medicine allergies? ☐ Yes ☐ No
   If yes, please list: _____
2. Does the student have any health conditions or illnesses? ☐ Yes ☐ No
   If yes, please list: _____
3. Has the student had any surgeries? ☐ Yes ☐ No
   If yes, please list: _____
4. Does the student take any medications regularly? ☐ Yes ☐ No
   If yes, please list: _____
5. Does the student have any lung, heart, or immune disorders? ☐ Yes ☐ No
   If yes, please list: _____

In the event of a medical emergency and if reasonable attempts to contact me using the telephone numbers listed above are unsuccessful:

I, as parent or legal guardian of the above student, do hereby authorize:

1. Treatment by a licensed medical physician of my child/ward in the event of a medical emergency that, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and
2. Transfer of my child/ward to any hospital reasonably accessible at my expense.

_____ _____

Parent/Guardian Signature Date

Medical Treatment & School Medication Authorization

***** TO BE COMPLETED BY THE CHILD'S PARENT(S)/GUARDIAN(S).***

** Student's Name:_____ Birth Date: _____ Grad Year: ____

*To be completed by the student's physician, physicians' assistant, or advanced practice RN (**Note:** for asthma inhalers only, use the "Asthma Inhalers" section below):*

Prescription Medication Name and Dosage: _____

Purpose: _____

Time/Frequency medication should be taken: _____

Anticipated number of days needed to take at school: _____

Possible Side Effects:_____

Physician's Signature _____Date: _____

Physician's Printed Name: _____

Office Address: _____ Office Phone: _____

Asthma Inhalers:

Parent(s)/Guardian(s) please attach prescription label here:

***** For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:***

I authorize the School District and its employees and agents, to allow my child or ward to self-carry and self-administer his or her asthma medication and/or epinephrine auto-injector: (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 the School District 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-carry and self-administration of asthma medication or epinephrine auto-injector.
(105-ILCS 5/22-30) ***If you agree, please initial:*** _____
Parent/Guardian

***** 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 and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **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 I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

CLEAR FORM PRINT