



MEDICATION AUTHORIZATION FORM (Asthma/Epi-Pen Permission Form)

Must be completed and turned in to the School Front Office annually.

To be completed by student's PARENT: *Please print in ALL CAPS*

Student's Name: _____
Date of Birth: _____
Grade: _____
Home Phone: _____
Mother/Guardian Name and Cell #: _____
Father/Guardian Name and Cell #: _____

To be completed by the student's PHYSICIAN: *Please print in ALL CAPS*

Physician's Printed Name: _____
Office Address: _____
Office Phone: _____
Emergency Phone: _____
Medication: _____
Dosage: _____
Frequency: _____
Time medication is to be administered or under what circumstance:

Prescription Date: _____
Order Date: _____
Discontinuation Date: _____
Diagnosis requiring medication: _____
Intended effect of this medication:

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: YES ___ NO ___

Expected side effects, if any: _____

Time interval for re-evaluation: _____

Other medications student is receiving:

Physician's Signature

Date

PARENT: SEE REVERSE SIDE (BOTH SIDES MUST BE COMPLETED)

MEDICATION AUTHORIZATION FORM (cont'd)
(Asthma/Epi-Pen Permission Form)

Parent/Guardian Authorization: Must be signed for ALL students

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 Hellenic American Academy and/or the Socrates Hellenic American Day School (collectively "the School") and their employees, volunteers and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of such employees, volunteers or agents), 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 trained healthcare professional, and specifically consent to such practices. I agree to indemnify and hold harmless the School, its affiliates and sponsors including without limitation Holy Trinity Greek Orthodox Church and the School Board and their respective officers, directors, employees, agents and volunteers 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. By my signature below, I warrant and represent that I am fully authorized to give this consent on behalf of the identified student and no further consents are required.

Mother/Guardian Signature

Printed Name and Date

Father/Guardian Signature

Printed Name and Date

Parent/Guardian Authorization: For students who require asthma medication or an EpiPen® only

I hereby authorize the Hellenic American Academy and/or the Socrates Hellenic American Day School (collectively "the School") and their employees, volunteers and agents, on my behalf, to allow my child or ward to possess and use his/her asthma medication and/or epinephrine auto-injector (1) during School or otherwise while on School grounds, (2) while at a School-sponsored activity, (3) while under the supervision of School personnel, or (4) before or after School activities. Separate from the release above, 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 from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30). By my signature, I warrant and represent that I am fully authorized to give this consent on behalf of the identified student and no further consents are required.

Mother/Guardian Signature

Printed Name and Date

Father/Guardian Signature

Printed Name and Date