

**Montessori School of Lemont**  
**Parental Authorization Form**  
**for Student Self-Administration of Medication at School**

To be completed every school year. Keep in the Executive Director's office.

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Classroom: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

*To be completed by the student's physician, physician assistant, or advanced practice RN:*

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

Physician's Office Address: \_\_\_\_\_

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

Emergency Number of Physician/Medical Provider: \_\_\_\_\_

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

Purpose: \_\_\_\_\_

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

Time medication is to be administered or under what circumstances: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Prescription Date: \_\_\_\_\_ Order Date: \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_

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

Is it necessary for this medication to be administered during the school day?  Yes  No

Expected side effects or intended effects school staff should be aware of, if any: \_\_\_\_\_

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

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

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Self-administration of medication was taught to the student by the parent/guardian under the supervision of a physician, including return demonstration:  YES  NO

For parent(s)/guardian(s) of students who need to carry asthma medication or an EpiPen:

I authorize Montessori Elementary School of Southwest Cook County (AKA Montessori School of Lemont) and its employees and agents, to allow my child or ward to possess and use 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 MSOL 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 initial:*** \_\_\_\_\_  
Parent(s)/Guardian(s) initial

***For all parents/guardians:***

1. I herewith acknowledge 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 Montessori Elementary School of Southwest Cook County (AKA Montessori School of Lemont) (MSOL) and its employees and agents, on 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 MSOL), 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 MSOL, its employees and agents arising out of the administration of said medication.
2. In addition, I agree to hold harmless and indemnify MSOL, 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, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the pupil.

\_\_\_\_\_  
Parent/Guardian Signature                      Date

\_\_\_\_\_  
Parent/Guardian Signature                      Date

\_\_\_\_\_  
Parent/Guardian Address

\_\_\_\_\_  
Cell Phone

Additional Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LEGAL REF.: 105 ILCS 5/10-20.14b, 5/10-22.21b, and 5/22-30.**

**Approved: November 1998**

**Revised: January 22, 2007**

The permission for self-administration of medication by the student is effective for the academic School Year only. Provided that the requirements of MSOL's Medication Policy are fulfilled, the pupil may possess and use his/her medication, including self-administration, a) while in school, b) while at school sponsored activities, c) while under the supervision of school personnel.

\_\_\_\_\_  
Administrator Signature                      Date

- Received *Student Self-Administration of Medication Authorization Form & Parental Authorization* (date: \_\_\_\_\_ Admin Initials: \_\_\_\_\_)
- Permission sent to parents (date: \_\_\_\_\_ Admin Initials: \_\_\_\_\_)