THE CHICAGO HIGH SCHOOL FOR THE ARTS

ChiArts Medication Authorization Form

Complete this form if your student takes ANY medications on a daily basis/during school hours.

Physician's Order

Student Name: _____ DOB: _____ ID# _____

NON-PRESCRIPTION MEDICATIONS – This authorization form is valid until graduation unless otherwise specified.

Medication: _____ Dosage: _____

Time Given/Frequency: _____ Route: _____

Reason for medication and/or intended effect: _____

PRESCRIPTION MEDICATIONS – This form must be completed annually for ALL prescription medications.
Prescription medication MUST be in containers labeled by a pharmacist.

Medication: _____ Dosage: _____

Time Given/Frequency: _____ Route: _____

Reason for medication and/or intended effect: _____

Possible side effects: _____

Other medications student is receiving: _____

Rescue inhaler and/or epipens injector – We recommend "back up" medication be stored in Nurses' Office.

1. Student may carry medication on his/her/their person. ☐ Yes ☐ No
2. Student may self-administer medication. ☐ Yes ☐ No

Directions for self-administration:

Physician's Name (Print): _____ Office Stamp/Address

Physician's Signature: _____

Date: _____ Phone(s): _____

PARENTAL AUTHORIZATION

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 The Chicago High School for the Arts and its employees and agents, in my behalf and instead 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 School District), medication according to the Medication Authorization Form.
2. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practices.
3. To indemnify and hold harmless the school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.
4. For parents/guardians of student who use rescue inhalers and/or epipens: I authorize the school district and its employees and agents to allow my child or ward to possess and use his/her asthma medication and/or epinephrine auto-injector: [1] while in school. [2] while at 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 parents[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 or epinephrine auto-injector (105 ILCS 5/22-30).
5. It is the responsibility of the parent[s]/guardian[s] to provide the school's health center with any changes or status updates.

Parent/Guardian Signature: _____ Date: _____

Emergency Phone: _____

THE CHICAGO HIGH SCHOOL FOR THE ARTS

Please complete the following forms only if applicable to your student.