Community Unit School District Number 7
510 West Elm Gillespie, IL 62033
Ph:(217) 839-2464 Fax:(217) 839-3353

Mr. R. Shane Owsley, Superintendent
Superintendent's Office
510 West Elm St.
Gillespie, IL 62033
Ph. (217) 839-2464
Fax (217) 839-3353

Mrs. Jill Rosentreter, Principal
Gillespie High School
612 Broadway St.
Gillespie, IL 62033
Ph. (217) 839-2114
Fax (217) 839-4302

Mrs. Tara Cooper, Principal
Gillespie Middle School
412 Oregon St.
Gillespie, IL 62033
Ph. (217) 839-2116
Fax (217) 839-3104

Mrs. Angela Sandretto, Principal
BenGil Elementary School
340 Kelly St.
Gillespie, IL 62033
Ph. (217) 839-4828
Fax (217) 839-3360

SCHOOL MEDICATION AUTHORIZATION FORM

* AN ASTHMA ACTION PLAN IS ALSO NEEDED WHEN AN INHALER IS PRESCRIBED

Student's Name:				Birth Date:	
Address:					
Home Phone:					
School:		Grade:		Teacher:	

To be completed by the student's physician/healthcare provider/licensed prescriber:

Name of Medication:					
Dosage:		Frequency:		Time to be given in school:	
Date of Prescription:		Date of Order:		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?					
Expected side effects, if any:					
Time interval for re-evaluation:					
Other medications student is receiving:					

Licensed prescriber's signature:	
Licensed prescriber's name (please print):	
Address:	
Office Phone:	
Emergency Phone:	
Date:	

I 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 Community Unit School District Number 7 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 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 arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify 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/guardian name (print):	
Parent/guardian signature:	
Date:	