Illinois Center for Autism

Medication Order/Consent Form

To: Parent or Guardian

The Illinois Center for Autism's policy and guidance from the Illinois State Board of Education states that all prescription and non-prescription medications that are given during school hours or school-related activities must have this form completed prior to the administration of any medication. Medication prescribed daily, twice, or three times daily should be administered outside of school hours. No medication will be given during the school day unless **absolutely necessary for the critical health and well-being of the student.**

All medication sent to school must be:

1. In the original prescription container or original manufacturer's package if non-prescription medication;
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, the time to be given, name of pharmacy; and
3. Medication should be brought to school by the parent/guardian or other responsible adult.

This medication form must be completed with the medication packaged properly as outlined above or the medication will not be given. Please return this completed form to the school nurse. Thank you.

INFORMATION OBTAINED FROM THE PHYSICIAN:

Student/client Name: _____ DOB:_____

Name of Medication and Dosage: _____

Route and Time: _____

Possible Side Effects: _____

Diagnosis/Reason for Medication: _____

Allergies_____

Other Medications: _____

Is this medication "absolutely necessary and critical" that the student receive this during school hours? ____YES _____NO

_____ _____

Physician's Signature & Date Physician Phone

_____ _____

Physician Printed Name Physician Fax

*548 South Ruby Lane * Fairview Heights, IL 62208 * Phone (618) 398-7500 * Fax (618) 394-9869*
*www.illinoiscenterforautism.org * Email: info@illinoiscenterforautism.org*

(Revised 10/2024)

PARENT AUTHORIZATION AND SIGNATURE:

I authorize the Illinois Center for Autism and its employees, on my behalf and stead, to administer or attempt to administer this lawfully prescribed medication and any prescribed changes. 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, i.e. school administrator or teacher. They are permitted to administer my child's medication. 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 agency, its employees, and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the district and its employees from any and all claims, damages, and causes of action or injury incurred or resulting from the administration or attempts at administration of said medication.

I allow the school RN or LPN to discuss this medication and its effects on my child with the prescribing physician, Advanced Practice Registered Nurse, Physician Assistant, or their representative.

_____ _____

Parent/Guardian Signature Date

_____

Student (If own guardian) Signature

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