Kinnikinnick CCSD #131

Kinnikinnick Kids Care

Medication Authorization Form

CHILD'S NAME: _____ AGE: _____

NAME OF MEDICATION: _____

DOSAGE: _____ FREQUENCY: _____ TIME: _____

DIAGNOSIS REQUIRING MEDICATION: _____

OTHER MEDICATION CHILD IS RECEIVING: _____

Must this medication be administered during Program hours in order to allow the child to participate in the Kinnikinnick Kids Care Program or to address his/her medical condition? _____YES _____NO

Expected side effects (if any): _____

_____

_____ _____ _____ _____

DOCTOR'S PRINTED NAME DOCTOR'S SIGNATURE DATE PHONE NUMBER

INSTRUCTIONS FOR CHILDREN WITH ASTHMA: _____

_____

_____

For parent(s)/guardian(s) of children who have asthma:
I authorize the Kinnikinnick Kids Care and its employees and agents, to allow my child or ward to possess and use his/her asthma medication (1) while in the Kinnikinnick Kids Care Program, (2) while under the supervision of Kinnikinnick Kids Care personnel or other Kinnikinnick School District personnel. 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 (105 ILCS 5/22-30).

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 School District 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 Kinnikinnick Kids Care personnel, and specifically consent to such practices, and
2. To indemnify and hold harmless the School District 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 child.

_____ _____ _____

PARENT / GAUARDIAN PRINTED NAME PARENT / GUARDIAN SIGNATURE DATE

MEDICATION ADMINISTRATION RECORD 2019/2020

KINNIKINNICK KIDS CARE

CHILD'S NAME: _____ DATE OF BIRTH: _____

MEDICATION: _____

_____

_____

2019									
10/11		10/14		11/15		11/22		11/27	
12/23		12/26		12/27		12/30			
2020									
1/2		1/3		1/17		1/20		2/21	
2/28		3/2		3/23		3/24		3/25	
3/26		3/27		4/13					

EMERGENCY DAYS									

LEGEND:

Initials=Medication Given A=Absent S=Self-administered R=Refused

O=Out of Medication H=Medication Held (see notes)

INITIALS/SIGNATURE: _____

_____

NOTES: _____

_____

_____