(Letterhead of School/district)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM

(Sample)

TO: PARENT OR GUARDIAN

Our district 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 PHYSICIAN:

Student Name: _____ Birth Date: _____

Name of Medication and Dosage: _____

Route and Time: _____

Possible Side Effects: _____

Diagnosis/Reason for Medication: _____

Other Medications: _____

Prescriber Approval for Self-Carry and Administration
(If allowed by school policy) _____ yes _____ no

Is parent requesting for student to carry and use emergency medication? _____ yes _____ no
(Inhaler/epinephrine/diabetic drugs and supplies)

_____ (Physician's Signature) _____ (Date)

_____ (Physician's Name - Please Print) _____ (Phone Number / Fax number)

PARENT AUTHORIZATION AND SIGNATURE:

I authorize (Name of school/district) and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-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, and have been informed of which staff member, other than RN or administrator, is 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 school district, 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 Registered Nurse 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)