BLOOMINGDALE SCHOOL DISTRICT 13

Authorization and Permission for Administration of Medication

THIS FORM IS REQUIRED IF YOUR CHILD IS TO RECEIVE NON-PRESCRIPTION AND/OR PRESCRIPTION MEDICATION AT SCHOOL AND/OR CARRY AN INHALER OR EPI-PEN.

STUDENT'S NAME: _____
DIAGNOSIS: _____
DOB: _____ **GRADE:** _____

School medications and health care services are administered following these guidelines:

Physician/Prescriber signed dated authorization to administer the medication.
Parent signed dated authorization to administer the medication.
The medication is in the original labeled container as dispensed or the manufacturer's labeled container.
The medication label contains the student name, name of the medication, directions for use and date.
Annual renewal of authorization and immediate notification, in writing, of changes.

Physician, please list medication that must be administered during school hours.

MEDICATION	DOSAGE	TIME TO BE ADMINISTERED	REASON PRESCRIBED	SIDE EFFECTS SPECIAL INSTRUCTIONS	RE-EVALUATE DATE

FOR SELF-ADMINISTRATION OF EPI-PEN and/or INHALER ONLY,

I certify that _____ has been instructed in the use and self-administration of _____
(Name of Student) (Name of Medication)

He/she understands the need for the mediation, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

_____	_____	_____
Signature of Physician	Phone number	Date
_____	_____	_____
Print Name of Physician	Address of Physician	Date

REVISED: 10/20/15