

BLOOMINGDALE SCHOOL DISTRICT 13

Authorization and Permission for Administration of Medication

Student's Name (Last) First Middle Birthdate School Date

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 Authorization:

Medication/Health Care Treatment Dosage Time to be administered

Intended effect of this medication Expected side effects, if any

Other medications student is taking

May student self-administer medication under supervision of Health Service personnel or designate?
(A student self-administration form must be completed) (Please Circle) YES NO

Administration instructions

Discontinue/Re-Evaluate/Follow-up Date (circle one)

Prescriber's Signature Date signed

Prescriber's Emergency Phone# Prescriber's Address

BLOOMINGDALE SCHOOL DISTRICT 13

Parental Authorization:

I herewith acknowledge 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 Bloomingdale School District 13 and its employees and agents, on 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 medications 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's Signature

Home Phone

Parent's Address

Business Phone

Date

Additional Information

BLOOMINGDALE SCHOOL DISTRICT 13

Physician Request for Self-Administration of Medication

Name of Student

Birthdate

City

Zip

Telephone Number

TO:

Principal: _____

School: _____

The above named pupil has _____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

Name of medication

Type of Medication (Tablet, Liquid or Capsule)

Dosage

Time(s) to be given

Possible Side Affects

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

of _____
(Name of Medication)

He/she understands the need for the medication, 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:

Phone Number of Physician

Signature of Physician

Date

Address of Physician

Print Name of Physician

Date