Authorization and Permission for Administration of Medication
("Or others as determined by state law", e.g. Asthma)

Student's Name (Last) (First) (Middle) Birth Date 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 to the manufacturer's labeled container.
- The medication label contains the student name, name of 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/are there possible other potential drug interactions

May student self-administer medication under supervision of Health Service personnel or designate?
(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

PARENTAL AUTHORIZATION

I hereby 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 Community High School District 218 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child, 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 an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when 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 except for willful and wanton conduct. In addition I agree, in the absence of willful and wanton conduct on the parent of the School District and its employees and agents, either jointly or severally, from the against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

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Parent/Guardian Signature Home Phone

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Parent Address Business Phone

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Date

Additional Information:

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