PEARL CITY C.U.S.D. #200

100 S. Summit Pearl City, Illinois 61062 815-443-2715 Fax - 815-443-2237

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM

******This form is good for current school year only******

DEAR PARENT OR GUARDIAN,

School Policy states that all prescription and non-prescription medications, that are given during school hours, must have this form completed prior to the administration of any medication. No medication will be given unless necessary for the health and well being of the student. For students who require the administration of multiple medications, please complete a separate form for each medication.

All medication sent to school must be:

1) In the original prescription bottle and labeled properly with the name of the student, the prescribing provider, name of the medication, dose, route, and frequency, name of pharmacy.
2) For non-prescription medication, medication should be sent in the original manufacturers package with the student's name written on the packaging.
3) Medication should be brought to school by the parent/guardian or other responsible adult.

Student Name:_____
Date of Birth:_____

Or Apply Label here

School Year_____ Grade _____

Homeroom Teacher_____

INFORMATION OBTAINED FROM PRIMARY CARE PROVIDER

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

Medication name:_____
Dose, Route and Frequency_____
Diagnosis/Reason for Medication_____ Side effects_____
Other Medications: _____

APPROVAL FOR SELF-ADMINISTRATION/CARRY EMERGENCY MEDICATION for JH/HS students ONLY.
By signing this form, I certify that this student has been instructed in the use and self-administration of this medication.

Inhaler or EpiPen (circle one)

_____ _____
(Primary Care Provider Signature) (Date)

_____ _____
(Primary Care Provider Name-Please Print) (Phone Number/Fax Number)

PARENT AUTHORIZATION AND SIGNATURE:

I authorize Pearl City School District #200 and its employees, on my behalf, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school district) to my child this lawfully prescribed medication and any prescribed changes. I acknowledge that it may be necessary for the administration of medication 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 release, hold harmless, and indemnify the District and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration.

_____ _____
(Parent/Guardian's Signature) (Date)

For Office Use Only: Unused medications returned to the parent/guardian on _____, by_____.