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******

TO: PARENT OR GUARDIAN

Our 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 absolutely necessary for the critical health and well being of the student.

All medication sent to school must be:

1) In the original prescription bottle or for non-prescription medication in the original manufacturers package;
2) Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time to be given, name of pharmacy; and
3) Medication should be brought to school by the parent/guardian or other responsible adult.

Please complete this form and return it to the school nurse. This information is to be kept confidential. Thank you for your cooperation.

Student Name:_____
Date of Birth:_____

Or Apply Label here

School Year_____ Grade _____

Homeroom Teacher_____

INFORMATION OBTAINED FROM PHYSICIAN

I am requesting that the above student take the following medication during school hours. I certify that he/she has been instructed in the use and self-administration of this medication.

Name of Medication and Dosage:_____
Route and Time _____
Diagnosis/Reason for Medication_____ Side effects_____
Other Medications: _____

APPROVAL FOR SELF-ADMINISTRATION/CARRY EMERGENCY MEDICATION (Inhaler/Epipen) Yes
(For Jr/Sr High Students) (Indicate yes or No)

_____ _____
(Physician Signature) (Date)

_____ _____
(Physician 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)