

MEDICATION AUTHORIZATION FORM

In accordance with School Code of Illinois, all students taking medication at school must complete this form. This applies to BOTH PRESCRIPTION MEDICATION AND OVER-THE-COUNTER PREPARATIONS. This form MUST be signed by both the physician and the parent/guardian and renewed each school year.

PHYSICIAN ORDER FOR ADMINISTRATION OF PRESCRIPTION OR OVER-THE-COUNTER MEDICATION:

Student's Name _____ Birthdate: _____
 School Winkelman Field _____ Grade _____
 NEEDS TO BE SENT ON FIELD TRIPS? YES NO
 Physician's Name _____ Phone: (____) _____
 Diagnosis _____
 Name of Medication _____
 Reason for Medication _____
 Dosage _____ Route of administration _____
 Frequency and time of administration _____
 Intended effect of medication _____
 Possible side effects _____
 Other medications student is receiving _____
 Discontinue/re-evaluate/follow-up _____ Date _____
 May student self-administer medication under supervision of Health Service personnel or designate? YES NO
 He/she is capable of using this medication independently and has been instructed in the use and self-administration of this medication. YES NO

Physician's Signature _____ Date: _____

Parent Authorization

I am aware that no medication, including any over-the-counter medication, such as Tylenol, will be given at school or a school related function without this signed form. The prescribed **medication must be brought to school by the parent/guardian** in a container appropriately labeled by the pharmacy or physician. Any unused medication not picked up by the designated date at the end of the school year will be discarded.

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 or if my child requires daily medication, I hereby authorize West Northfield School District 31 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 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 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 Signature _____ Date _____

Phone (Home) _____ Phone (Work) _____

Field School Fax Number – (847) 272-1050 Phone (847) 313-4454

Winkelman School Fax Number – (847) 729-5654 Phone (847) 832-2205