revision of 7.270-E; May 2011

EDWARDS COUNTY COMMUNITY UNIT SCHOOL DISTRICT #1
SCHOOL MEDICATION AUTHORIZATION FORM

In order to comply with the guidelines recommended by the Illinois Department of Public Health, the Illinois State Board of Education, and the Illinois Association of School Nurses for administering medication in school, we need the following information from the licensed prescriber and a written request from the parent/guardian requesting the medication be given during school hours.

A written order for PRESCRIPTION AND NON-PRESCRIPTION medications must be obtained from the child's licensed prescriber. (Orders should be renewed annually for long-term medications and any changes should be reported in writing.)

Medication must be brought to school in a container appropriately labeled by the pharmacy or physician. Non-prescription medications ordered by the physician should be brought with the original label and the student's name affixed to the container. Only those medications which are necessary to maintain the student in school or must be given during school hours shall be administered. If you have any questions, please call the school nurse.

Child's Name: Last First	Birthdate / /
Grade:	Teacher:
Name of medication:	
Dosage:	Frequency:
Time to administer:	
Date of Prescription:	
Diagnosis Requiring Medication:	
Date of Order	Discontinuation Date:
Intended effect of the medication:	
Expected Side Effects, if any:	
Time interval for re-evaluation:	
Other medications student is receiving:	
Further instruction remarks:	

Physician's name - signature

Address
Phone - Office

I hereby certify authorization 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 Edwards County Community Unit School District and its employees and agents, in 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 HEALTH PROFESSIONAL, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I 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 of injuries incurred or resulting from the administration or attempts at administration of said medication.

PARENT'S SIGNATURE DATE PARENT'S PHONE