West Carroll Community Unit District No. 314

Student Medication Authorization

Our school policy states that medications are given by a nurse or principal's designee to a student only upon the written prescription of a physician AND the written request of a parent.

All medication sent to school must be properly labeled with the name of the student, doctor, name of medication, dosage and time to be given, purpose of medication, possible side effects, and the termination date for administering the medication.

Please complete this form and return it to the school nurse. This information is kept confidential between physician, parent, teacher and school nurse. Thank you for your cooperation.

School Nurse ______________________________ School______________________________ Date________________________

Physician or Nurse Practitioner Printed Name_________________________________ Office Phone__________________________

Name of Student____ D.OB.__________________________ Grade______________

Medication_________________________________ Dosage_______________ Route _______Time to be Taken_______________

Purpose of Medication____

OR

______ Acetaminophen (Tylenol) 325mg tabs. Give 1-2 tabs for pain or fever by mouth as needed every 4-6 hours.
______Diphenhydramine HCl (Benedryl) 25mg caps. Give 1-2 caps for allergy symptoms by mouth as needed every 4-6 hours.
______Ibuprofen (Advil) 200mg tabs. Give 1-2 tabs for pain or fever by mouth as needed every 4-6 hours.
______Calcium Carbonate (Tums) 500 mg tabs. Give 1-2 tabs for upset stomach or indigestion by mouth as needed.
______Cough Drop. Dissolve 1 lozenge for sore throat or cough by mouth as needed every 2 hours.

Termination Date for
Administration of Medication___________________________ Doctor's Signature______________________ Date____________

For all parents/guardians:

By signing below, I agree 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 the school district and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law, 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, and I agree to indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. I am requesting that the school nurse or principal's designee give the above named prescription to:

Student's Name_____________________________________ Time to be taken____

Parent Signature ____ Date______________________________

For only parents/guardians of students who need to carry asthma medications or an epinephrine auto-injector:

I authorize the school district and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector:

(1) while in school,
(2) while at a school-sponsored activity,
(3) while under the supervision of school personnel, or
(4) before or after normal school activities, such as while in before-school or after school care on school-operated property.

Illinois law requires the school district to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree please initial _______