MOLINE SCHOOL DISTRICT # 40
REQUEST FOR THE ADMINISTRATION OF MEDICINE OR TREATMENT

The administration of medicine is normally not a function of education, but if it does become necessary for a student to take medicine at school, the State of Illinois mandates that the following guidelines be followed:

1. Provide the building principal or nurse with the district medication form completed, signed and dated by the physician and the parent/guardian for prescription medication.
2. Non-prescription medication such as pain relievers, anti-inflammatories, antacids, antihistamines, and cough syrup/drops do not require a physician's signature but all other information relative to the medication must be completed and signed by the parent/guardian.

****It remains the discretion of school officials, including the school nurse, which items may be administered without a physician's signature.**

3. Medication must be delivered to the nurse's office by the parent/guardian, unless prior arrangements have been made to independently carry an inhaler or epi-pen
4. School policy prohibits students from having in their possession prescription or nonprescription medication other than inhalers or epi-pens which have been pre-approved by the nurse.
5. Medication ordered by an MD must be delivered to the nurse in the prescription bottle with the pharmacy label indicating directions for administration.
6. Non-prescription medication must be in the original container and administered according to label directions.
7. Notification should be received when a drug is discontinued or a change in dosage or interval occurs.
8. Medication guidelines must be renewed annually.

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PLEASE NOTE: The school does not assume responsibility for medication which is not delivered to or kept in the school office or other secure designated areas.

PLEASE PRINT:

Student's Name_____Grade_____Date of Birth_____

Parent's/Guardian's Name_____Emergency Phone#_____

PHYSICIAN'S/ PARENT'S REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL

Disease/Illness Involved_____

Medicine /Treatment_____ Time to be administered_____

Dosage and directions for administration at school_____

Discontinuation Date_____ Possible Side Effects_____

Does this student require possession of asthma and/or epi-pen medication/treatment to use without the supervision of school personnel? *Yes_____ No_____

***A student self-administration form must be completed (Form M-2b)**

_____
Print Physician Name

_____ _____ _____
Physician's Signature Telephone# Date

_____ _____ _____
Parent/Guardian Signature Telephone# Date

PARENTAL AUTHORIZATION

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, I hereby authorize **Moline School District No.40** and its employees and agents on my behalf and stead, to administer or to attempt to administer to y 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

(2015)

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Parent's/Guardian's Signature Date