HINSDALE SOUTH HIGH SCHOOL

*A Partnership in Learning*

Arwen Pokorny Lyp, Principal
Eric Martzolf, Assistant Principal for Curriculum & Instruction
Dr. Kari Peronto, Assistant Principal for Operations
Michael Holland, Director of Counseling
Robin Vannoy, Director of Deans
Kristin Marks Pascavage, Director of Special Education
Lynn Hatzikostantis, Activities Director
Art Ostrow, Athletic Director

**HINSDALE SOUTH HIGH SCHOOL HEALTH OFFICE**

PHONE: 630-468-4595 FAX: 630-468-4615

**MEDICATION AUTHORIZATION FORM**

Student Name: _____ID:_____ DOB: _____

**TO BE COMPLETED BY THE PHYSICIAN**: (please print)

All medication requires authorization each school year. It is the parent's responsibility to update student health information in the event of any change.

**Medication Required during School Dosage/Time/Frequency Diagnosis/Intended effect**

1._____

2._____

3._____

**Physician's Signature_____Phone_____Fax_____**

**SELF MEDICATION ONLY**

**Medication student may carry and self-administer: Inhaler, Insulin or Epi-Pen** (circle if applicable). **If a student will be utilizing insulin or an epi-pen the corresponding action plan must be completed by the physician and parent. For students that self-carry an Inhaler, attach a copy of the medication label and provide a parent's signature at the bottom of this form**. The appropriate (asthma, diabetic, allergy and anaphylaxis) action plan(s) can be downloaded from our website. Please contact the school nurse at630-468-4595 if you have any questions or concerns.

**Self-Administered Medication: such as medication for diabetes, severe allergy or other specified condition**: I or a member of my staff has instructed the above student in the proper administration of the self-administered medication. He/she understands the need for the medication, the appropriate response, and the necessity to report to school personnel any unusual side effects or lack of appropriate response. The student is capable of using this medication independently.

Physician's Signature _____ Phone _____Fax_____

Physician's Name _____ Date_____

**Parent/Guardian's Authorization By signing below:** I hereby 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 Hinsdale Township High School District 86 and it employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer) the 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 the school nurse, and specifically consent to such practices. I further acknowledge and agree that, when 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 any and all claims, damages, and causes of action or injuries, except a claim based on willful and wanton conduct, incurred or resulting from the administration or self-administration of medication.

**Parent/Guardian's Signature**_____ Date _____