SCHOOL MEDICATION AUTHORIZATION FORM

Lemont High School • 800 Porter Street • Lemont, IL 60439 • Phone: (630) 243-2321 • Fax: (630) 243-7904 • www.lhs210.net

This form must be completed annually for <u>each medication</u> and will be maintained in the Nurse's Office.

Student's Name: _____ **Birth Date:**____ / ____/ _____ **Grade: 8 9 10 11 12**
(please circle)

Address:_____
(Street) **(City)** **(State)** **(Zip)**

Phone: ( ) _____ **Parent/Guardian E-Mail Address:**_____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, A PHYSICIAN'S ASSISTANT, OR AN ADVANCED PRACTICE REGISTERED NURSE

Physician's Name: _____ **Phone:** ( ) _____

Address:_____
(Street) **(City)** **(State)** **(Zip)**

MEDICATION	PURPOSE	DOSAGE	ROUTE	FREQUENCY/CIRCUMSTANCES/ TIME OF ADMINISTRATION

Prescription Date: ____/____/____ **Order Date:** ____/____/____ **Discontinuation Date:** ____/____ / ____

Diagnosis Requiring Medication:_____ **Time Interval for Reevaluation:** _____

Expected Side Effects/Special Instructions (if any): _____

Is it necessary for this medication to be administered during the school day? *(please circle)* **YES NO**

Equipment Prescribed by Physician: _____

Student's Other Medications: _____

Physician's Signature:_____ **Date:** _____/_____ / _____

For all parents/guardians

I acknowledge that I am primarily responsible for administering medication to my child or ward. However, in the event that I am unable to do so, or in the event of an emergency, I authorize Lemont High School District 210 and its employees and agents, on my behalf, to administer or to attempt to administer to my child or ward the lawfully prescribed medication described above in the manner described above. **I acknowledge that it may be necessary for the administration of medication to my child or ward to be performed by an individual other than a school nurse and specifically consent to such practices**. I agree to indemnify and hold harmless District 210 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of medication. **<u>I acknowledge that the only medications (both prescription and over-the-counter) that students are permitted to self-carry and/or self-administer are: (i) asthma medication and/or epinephrine auto-injectors (if authorized pursuant to a Self-Administration/Self-Carry School Medication Authorization Form); and (ii) diabetes monitoring supplies and insulin (per applicable Student Handbook provisions).</u>** It is my responsibility to notify the School Nurse of any change in my child's health status or medication/health procedure. **This authorization is effective for the duration of the school year during which the form is signed by the parent/guardian. This form must be renewed for each subsequent school year. I understand that I may revoke the authorizations contained herein at any time in writing.**

Parent/Guardian's Name (printed): _____ **Emergency Phone:** ( )_____

Parent/Guardian Signature: _____ **Date:** _____/_____ / _____