West Aurora School District 129

WEST AURORA • NORTH AURORA • MONTGOMERY • SUGAR GROVE • BATAVIA

West Aurora School District #129
Medication Authorization Form

Student's Name: _____ Student ID: _____

School: _____ Birthdate: _____ Grade: _____

I hereby authorize West Aurora School District #129, and its employees and agents, on my behalf, to administer or attempt to administer, to my child, or allow my child to self-administer, while under the supervision of the employees and agents of the School District, in the manner described below. I acknowledge that it may be necessary for the administration of medication(s) to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I will bring the medication to the school's health office in a container labeled by the pharmacy and will notify the school with any medication changes (medication/dosage/frequency changes require an updated medication authorization form). I understand that it is the responsibility of my student to report to the health office at the scheduled time to receive the medication.

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 West Aurora School District, its employees and agents, either jointly or severally, against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration, or attempt at administration, of said medication.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN FOR ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATION(S):

Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition? YES _____ NO _____

Name of Medication: _____
Dosage / Frequency / Route of Administration: _____
Diagnosis requiring medication: _____
Intended effect of this medication: _____ Side Effects: _____
Other medications the student is receiving: _____

For Asthma, Epinephrine and Diabetic Medications (Insulin, Glucagon) only:
Will this student self carry medication? YES _____ NO _____
Will a second set of medication be kept in the health office at school? YES _____ NO _____

Date or Prescription: _____ Discontinuation Date: _____

Physician's Name: _____ Physician's Signature: _____ Date: _____

Address of Physician: _____ Telephone Number: _____

Any questions associated with the information requested can be directed to the school's nurse.
LINK: District 129 School Nurses

West Aurora School District 129

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Distrito Escolar West Aurora #129
Formulario de Autorización de Medicamentos

Nombre del estudiante: _____ Fecha de nacimiento: _____

Escuela: _____ Grado: _____

Por la presente autorizo al Distrito Escolar West Aurora #129 y a sus empleados y agentes, en mi nombre, a administrar o intentar administrar a mi hijo, o permitir que mi hijo se autoadministre, bajo la supervisión de los empleados y agentes del Distrito Escolar, de la manera que se describe a continuación. Reconozco que puede ser necesario que la administración de medicamentos a mi hijo sea realizada por una persona que no sea la enfermera de la escuela y doy mi consentimiento específico para tales prácticas. Llevaré el medicamento a la oficina de salud de la escuela en un recipiente etiquetado por la farmacia y notificaré a la escuela cualquier cambio de medicamento (los cambios de medicamentos/dosis/frecuencia requieren un formulario de autorización de medicamento autorizado). Entiendo que es responsabilidad de mi estudiante presentarse en la oficina de salud a la hora programada para recibir el medicamento.

Además, reconozco y acepto que cuando el medicamento recetado legalmente se administre o intente administrar,renuncio a cualquier reclamo que pueda tener contra el Distrito Escolar de West Aurora, sus empleados y agentes, ya sea en forma conjunta o individual, contra cualquier y todos los reclamo, daños, causas de acción o lesiones, incluidos los honorarios razonables de abogados y los costos gastados en defensa de los mismos, incurridos o resultantes de la administración de dicho medicamento.

Firma de padre/tutor: _____ Fecha: _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN FOR ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATION(S):

Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition? YES _____ NO _____

Name of Medication: _____
Dosage / Frequency / Route of Administration: _____
Diagnosis requiring medication: _____
Intended effect of this medication: _____ Side Effects: _____
Other medications the student is receiving: _____

For Asthma, Epinephrine and Diabetic Medications (Insulin, Glucagon) only:
Will this student self carry medication? YES _____ NO _____
Will a second set of medication be kept in the health office at school? YES _____ NO _____

Date or Prescription: _____ Discontinuation Date: _____

Physician's Name: _____ Physician's Signature: _____ Date: _____

Address of Physician: _____ Telephone Number: _____

Cualquier pregunta relacionada con la información solicitada puede dirigirse a la enfermera de la escuela.
ENLACE: Enfermeras del Distrito Escolar 129