

Warren Township High School

Almond Campus
847-548-6899
Fax: 847-548-7171

O'Plaine Campus
847-599-4766
Fax: 847-599-4679

MEDICATION FORM

Do not use this form for epinephrine auto-injectors or asthma inhalers/medication - please use the Allergy and/or Asthma Action Plan forms.

STUDENT NAME: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE LICENSED PRESCRIBER (MD/APN/PA-C):

Medication/Dosage/Frequency: _____

Duration (Length of time to be given): _____

Diagnosis or symptom for which medication is given: _____

Medication/Dosage/Frequency: _____

Duration (Length of time to be given): _____

Diagnosis or symptom for which medication is given: _____

Medication/Dosage/Frequency: _____

Duration (Length of time to be given): _____

Diagnosis or symptom for which medication is given: _____

Other medications student is taking at home: _____

Licensed Prescriber (print name): _____ **Phone #:** _____

Signature: _____ **Fax #:** _____

Date: _____

TO BE COMPLETED BY PARENT:

I hereby request and grant permission for school district #121 school personnel to administration of medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a certified/registered school nurse, and I specifically consent to this. I further waive any claims against the School District, members of the Board of Education, its employees, and agents, arising out of the administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the administration of medication.

I have read and understand the medication administration procedure for District 121. I request and authorize medication to be given to my child.

Parent signature: _____ Date: _____