

HOMER SCHOOL DISTRICT 33C SCHOOL MEDICATION AUTHORIZATION FORM

In accordance with the recommendation of the Illinois Office of Education, the following is an explanation of the district policy for the administration of medication during school hours.

All attempts should be made to schedule the medicine to be given at home. If it is necessary for medication to be taken at school, we urge you to come to school to administer it. Students are not allowed to keep medicine in their possession at school. Inhalers and Epinephrine auto-injectors may be carried and administered by students if the appropriate forms have been submitted. Medicine will be administered by school personnel only if necessary for the student to remain in daily attendance, or in an urgent or emergency situation.

In order to protect the student and school personnel, we must have on record a signed statement from both parent and physician giving the school permission to administer such medication. Forms are available from the building attendance office. Medication must be brought to school by the parent or guardian, properly labeled by the pharmacy or by the physician. The label must contain the child's name, doctor's name, pharmacy name, medication name, prescription number, and specific instructions for administration. The student must remember to appear in the office for his/her medication. School personnel cannot assume responsibility for reminding the student. All medication will be kept in a locked cabinet, with the exception of Epinephrine auto-injectors and antihistamines, which will be kept in a secure, unlocked designated area. Over the counter medication must be in the original container. All medications dispensed at school must be delivered in the original container prior to the start of the current school year.

PHYSICIAN'S WRITTEN ORDER FOR MEDICATION

Date _____

Name of Child _____

Drug _____

Dosage _____

Time Interval _____

Diagnosis _____

Side Effects _____

Physician's Emergency Telephone Number _____

PHYSICIAN'S SIGNATURE _____

PARENTAL CONSENT TO ADMINISTER MEDICATION

The undersigned parent(s)/guardian(s) of _____

hereby request that said student be given medication as prescribed by _____ (name of pharmacy)

as prescription number _____

Name of medication _____ Dosage _____

to be given at the hour(s) of: _____ or at times as close thereto as is reasonably possible. The undersigned releases Homer School District 33C, its Board, Agents, and Employees from all claims that may arise as a result of action or inaction resulting from the request herein made. It is understood that the parent(s) or guardian(s) accept full responsibility for the giving of medication.

Signature _____ Date _____ Phone _____

September 2015