McHenry School District 15
420 N. Front Street, McHenry, Illinois 60050
www.d15.org

REQUEST FOR THE ADMINISTRATION OF MEDICINE AND HEALTH CARE TREATMENT

Medications cannot be administered at school without a doctor's written order and a written request from the parent(s)/guardian(s). If possible, we request that medication be scheduled so as to not be given at school.

Student Name _____ Parent(s)/Guardian(s) Name _____

Address _____ Birthdate _____ Grade _____

School _____ Home Phone _____ Emergency Phone _____

The following information is to be completed by the physician:

Medication Name/Health Treatment: _____

Medication Administration Period: _____ Start date _____ End date

Time of day to be Administered: _____ Dosage _____ Route _____

Diagnosis for Medication/Health Treatment and Intended Effect: _____

Possible Side Effects and/or Negative Drug Interactions: _____

Physician Printed Name _____

Signature of Physician _____ Date _____ Phone _____

PARENT REQUEST FOR ADMINISTRATION OF MEDICINE AT SCHOOL

It is the belief of the Board of Education that medication should be administered at home. However, under certain conditions, it is in the best health and educational interest of the child to take prescribed medications during the school day. In such cases, the medication **must be prescribed by a doctor and a parental request must be on file in the Health Office.** To ensure compliance with the rules for administering medication at school, **medication must be brought to school by the parent or other responsible adult, in the original container properly labeled with directions and the doctor's name**. The student is responsible for coming to the Health Office to take the medicine. The parent of the student must assume responsibility for informing the school of any change in the child's health or change in medication. **Any change in medication or dosage will require a new request form to be submitted.** The School District retains the discretion to reject requests for the administration of medication. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a Registered Nurse and specifically consent to such practice. I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self administration of medication.

I request that the nurse or Building Principal make provision for my child _____ to receive the medicine prescribed by Dr. _____ according to the instructions listed above. I also give permission for the nurse to contact the above physician in regard to any medication concerns.

_____ _____
Parent/Guardian Signature Date

Students Who Need to Carry Inhalers or an EpiPen® I authorize the School District and its agents to allow my child to possess and use his or her asthma medication and/or EpiPen®. I have instructed _____ in the proper way to use his/her medication.

_____ _____ _____ _____
Physician Signature Date Parent/Guardian Signature Date