COMMUNITY CONSOLIDATED SCHOOL DISTRICT 15

MEDICATION ADMINISTRATION AUTHORIZATION

STUDENT NAME		**DATE OF BIRTH**	
PARENT/GUARDIAN		**PHONE NUMBER**	
ALLERGIES		**GRADE**	

District 15 believes that parents/guardians have primary responsibility for the administration of medication to their children. Therefore, the Board of Education discourages the administration of medication during regular school hours and during school-related activities, unless necessary for the health and well-being of the student. In order for medication to be administered at school, a student's parent/guardian and physician/authorized prescriber must complete and sign this form each school year for each prescription and non-prescription (over-the-counter) medication.

Medication brought to school for administration must be in its original prescription-labeled container from the pharmacy or healthcare provider or in the original over-the-counter medication container and clearly labeled with:

1. Student's name 2. Medication name and dosage 3. Schedule for medication administration

Medication **must** be brought into school by a parent/guardian and verified with the school nurse. Medication remaining at the end of the year **must** be picked up by a parent/guardian or it will be destroyed.

TO BE COMPLETED BY THE PHYSICIAN/AUTHORIZED PRESCRIBER

Reason for Medication/Diagnosis: _____

Is it necessary for the medication to be administered during the school day? ☐ Yes ☐ No

Medication Name: _____

Dosage: _____ Route: _____Frequency/Specific Times: _____

Possible Negative Side Effects:_____

Comments/Additional Instructions: _____

Other medications the student is taking: _____

School Year _____ Start Date _____ End Date _____ ☐ Emergency Action Plan attached

Authorized Prescriber's Name (print or stamp)_____

Authorized Prescriber Address: _____

Authorized Prescriber's Phone: _____ Fax_____

Authorized Prescriber Signature_____Date _____

TO BE COMPLETED BY ALL PARENTS/GUARDIANS

I hereby acknowledge that I have reviewed and understand the District's medication policies and procedures. By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the District and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law and Board policy, while under the supervision of the employees and agents of the District), lawfully prescribed medication in the manner described above. This includes administration of undesignated asthma medication, epinephrine injectors, or opioid antagonists, to the extent the District maintains such undesignated supplies, to my child when there is a good faith belief that my child is having an asthma episode, anaphylactic reaction, or opioid overdose, whether such reactions are known to me or not. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I agree to indemnify, release, and hold harmless the District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of medication, or my child's self-administration of medication, including asthma medication or epinephrine injectors, or medication required under a qualifying plan.

Parent/Guardian Signature_____Date_____