



Self Administration of Medication

Dear Parent/Guardian,

We want to make every effort to help your child be successful in school. If it is necessary that your student take medication regularly or as needed during school time, please sign the attached form and have it signed by your student's health care provider so the nurses in the HFHS Health Service Office can administer. The medication must be brought to the Nurse's Office, in a bottle labeled by the pharmacist along with this form filled out by your healthcare provider and signed by you. Long-term over-the counter medications should be in the original container. All medications should be picked up at the end of the school year and orders renewed at the beginning of the new school year. We will dispose of any medication left when school closes in June. A provider's order is needed for students to carry and self-administer their own EpiPen®. A parent or guardian signature and copy of the prescription label is required for students to carry and self-administer an emergency asthma inhaler.

Thank you,

Lottie Parker, RN, BSN, CSN/PEL
Dr. Valarie Leak, DHA, MBA, BSN, RN, CSN/PEL
Health Services

Estimado Padre/Tutor,

Queremos hacer todo el esfuerzo para ayudar a su hijo a ser exitoso en la escuela. Si es necesario que su estudiante tome medicación de manera regular o según lo necesite durante las horas de clases, por favor firme el formulario adjunto y hágalo firmar por el proveedor de salud de su estudiante para que las enfermeras en la Oficina del Servicio de Salud de HFHS puedan administrárselo. La medicación debe ser traída al Servicio de Salud, en una botella etiquetada por el farmacéutico junto con el formulario lleno por su proveedor de salud y firmado por usted. Los medicamentos sin prescripción de largo plazo deben estar en el recipiente original. Todas las medicinas deben ser recogidas al final del año escolar y las órdenes deben ser renovadas al comienzo del nuevo año escolar. Nosotros dispondremos de toda medicina sobrante cuando la escuela cierre en junio. Se necesitará una orden del proveedor de salud para que los estudiantes pueden llevar consigo y auto-administrarse su propio EpiPen®. Se requiere la firma del padre o tutor y una copia de la etiqueta de la prescripción para los estudiantes que portan y se auto-administran el inhalador para el asma.

Gracias,

Lottie Parker, RN, BSN, CSN/PEL
Dr. Valarie Leak, DHA, MBA, BSN, RN, CSN/PEL
Servicio de Salud de HFHS



Self Administration of Medication Form

Homewood Flossmoor High School District 233

999 Kedzie Ave, Flossmoor IL 60422

(Please print clearly in black ink)

For school use only:

Medication:	
Exp. Date:	

Homewood Flossmoor High School Health Services

Phone: 708-335-5536

Email: medicalrecords@hf233.org

North Building Nurse: Lottie Parker

South Building Nurse: Valerie Leak

Health Services Clerk: Danni Werner

PHYSICIAN/NP/PA ORDER

Student Information

Student's Name:				Date of Birth:	/ /
Medication:		Dosage/Route		Time&Freq.	
Medication:		Dosage/Route		Time&Freq.	

Specific Instructions:

Starting Date:		Ending Date:	
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Diagnosis for this medication and intended effect:

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

Possible side effects:

Other medications prescribed for this student:

Emergency Medication

Emergency Medication: EpiPen® and Inhalers ONLY

911 will be called if EpiPen is administered or self-administered.

MD/PA/NP must initial choice(s) below:

☐	Student may carry this medication on his/her person. (It is recommended that "back-up" medication be stored in the school health office.)
☐	Student may self-administer medication. I have instructed the student on the administration of this medication and find that he/she is able to administer this medication independently.

Health Care Provider Information

Health Care Provider Name: (please print)		Phone Number:	()
Address:			
Health Care Provider Signature:		Date:	/ /

Parent/Guardian Authorization / Autorización del Padre/Tutor

I, _____, parent/guardian of _____ hereby authorize Homewood-Flossmoor High School District 233 and its employees and agents, to administer or to allow the self-administration of the lawfully prescribed medication described above. I further acknowledge and agree that, when lawfully prescribed medication taken according to the directions provided, I waive any claims I might have against the School District and staff arising out of the administration or self-administration of said medication. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, from and 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 of said medication.

_____/_____/_____
Date Parent/Legal Guardian (Signature) () Daytime phone number

Yo, _____, padre/tutor de _____ por el presente autorizo de la Escuela secundaria Homewood Flossmoor Distrito 233 a sus empleados y agentes, administrar o permitir la auto-administración de la medicación legalmente prescrita descrita más arriba. Yo además reconozco y estoy de acuerdo que, cuando la medicina prescrita legalmente tomada con las indicaciones brindadas, yo exoneró de cualquier reclamo que podría tener contra el Distrito Escolar y personal que surja de la administración o auto-administración de dicha medicación. Además, estoy de acuerdo en indemnizar y mantener indemne al Distrito Escolar, sus empleados y agentes, de y contra cualquier y todo reclamo, daños, causas de acción o lesiones, incluyendo costas de abogados y costos gastados en defensa incurridos o resultantes de la administración de dicho medicamento.

_____/_____/_____
Fecha Padre o Tutor Legal (Firma) () Número telefónico de día

PLEASE NOTE:

Over-the-counter medication MUST BE in the manufacturer's labeled container.

Prescription medication must be in container labeled by a MD/PA/NP or pharmacist.

Por favor tome nota:

La medicina sin prescripción DEBE ESTAR en el envase de fábrica con su etiqueta.

La medicina de prescripción debe estar en un envase etiquetado por un MD/PA/NP o farmacéutico.



HOMEWOOD-FLOSSMOOR COMMUNITY HIGH SCHOOL DISTRICT 233

Health Immunization Record Request

Please allow up to 5 business days to process your request.

Note: If you graduated prior to 1978 we will not have your immunization records. Please call your healthcare provider. This form is not to be used by current HFHS Students.

Your Information

Name* _____, _____ Email* _____
First Last

Address*

Street Address City State Zip Code

Phone Number

Student Information(at time of attendance)

Name* _____, _____ Graduation Year* _____
First Last

Date of Birth* _____

Immunization Record Request Details

Please send my immunization records via(choose one)*

☐ Email _____

☐ Fax: _____

☐ Other: _____

Recipient's Name* _____ Attention to: _____

Comments: _____

Health Immunization Request Details*

I, _____, authorize Homewood-Flossmoor High School Health Service Office to release my medical records, to the recipient named above. I understand that I can revoke this authorization in writing at any time, except to the extent that information has been released in reliance upon this authorization. I also understand that the information released may be subject to re-disclosure by the recipient. I have a right to inspect and receive a copy of my protected health information.

Signature Date