Queen Bee School District 16
1560 Bloomingdale Road
Glendale Heights, IL 60139

MEDICATION ADMINISTRATION FORM
FOR PRESCRIPTION AND NONPRESCRIPTION MEDICATIONS

STUDENT NAME: _____ BIRTHDATE: _____
SCHOOL: _____GRADE:_____
PARENT NAME: _____
EMERGENCY TELEPHONE: _____
DIAGNOSES: _____ _____
NAME OF MEDICATION: _____
DOSAGE: _____

- **Medication administration in the school setting is to help the student maintain an optimal state of health to enhance his/her education.**
- **It is the parents' responsibility to bring all medications and required medical equipment to school.**
- **At the end of the prescribed treatment or school year, it is the parent's responsibility to remove any unused medication or medical equipment from the school. All medications not removed from school are disposed of according to the Illinois Department of Public Health Guidelines.**
- **No medications are administered at school until all paperwork is submitted and the medicine is appropriately labeled in the original container.**
- **Medications (prescription or non-prescription) are maintained and administered in the health office. Students may not carry, possess, or self-administer medicine at school.**

I, _____ (Parent/guardian) of_____(student's name), hereby authorize Queen Bee Schools, District 16 and its employees and agents, in my behalf and stead, to administer my child's medications needed as lawfully prescribed. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees, and agents arising out of the administration of said medication. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, 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.

Parent/GuardianSignature_____Date_____

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To be completed by a physician

STUDENT NAME: _____ **DATE OF BIRTH:** _____

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____ **ROUTE:** _____

DURATION OF ADMINISTRATION: _____ **SCHOOL YEAR** _____

INTENDED EFFECT: _____

POSSIBLE SIDE EFFECTS: _____

_____ _____

Physician Name **Physician Signature**

_____

Physician Phone

Date: _____

Additional physician orders: _____

_____