

**LEMONT-BROMBEREK COMBINED SCHOOL DISTRICT 113A**  
**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

In the event that a parent requests that a student take medication during the school day, please follow these procedures. **Note:** *Different forms are required for asthma and allergy medications.*

1. The form below must be completed by the parent or guardian.
2. The form below must be completed by the physician.
3. The completed form below must be on file at school before the medication can be administered at school.
4. The medication must be in the original labeled container as dispensed or in the manufacturer's labeled container. The label must contain the student's name, name of the medication and directions for use and date.
5. Parents or other authorized adults must transport medications and medical supplies to and from school; students may not carry medications or supplies.
6. All unused medications that have not been picked up by parents by the last day of each school year will be discarded by health office staff.
7. Immediate written notification of changes must be provided to the school by the parent/guardian.
8. Annual renewal of authorization is required.

**NO MEDICATION WILL BE ADMINISTERED AT SCHOOL IN THE ABSENCE OF A COMPLETED, APPROVED AUTHORIZATION FORM.**

**TO BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN**

Student's Name \_\_\_\_\_ (please print)  
Student's Date of Birth \_\_\_\_\_ School \_\_\_\_\_

I request that the above-named student be given the medication indicated below or supervised while self-administering the medication by an employee of the school district who has been designated by the Superintendent or Building Principal. I understand that the school system is not bound to honor this request. In consideration of the school's acceptance of this request, the undersigned acknowledges and agrees that the School District and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from the administration of medication to my child at school. I further acknowledge and agree that, in the absence of willful and wanton conduct on the part of the School District and its employees and agents, I waive any claims that I might have against said parties arising out of the administration of said medication to my child at school. In addition, I agree to indemnify and hold harmless the School District and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from administration of said medication to my child at school.

Parent/Guardian Name \_\_\_\_\_ (please print)  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
Home Telephone Number \_\_\_\_\_ Work Number \_\_\_\_\_ Cell Number \_\_\_\_\_

**TO BE COMPLETED BY LICENSED PRESCRIBER**

Child's Name \_\_\_\_\_ (please print)  
Medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Frequency \_\_\_\_\_ Time of Administration \_\_\_\_\_  
Route of Administration \_\_\_\_\_  
Diagnosis requiring medication and reasons that medication must be given during school hours \_\_\_\_\_  
Date of Prescription \_\_\_\_\_ Date of Order \_\_\_\_\_ Date of Discontinuation \_\_\_\_\_  
Intended Effect \_\_\_\_\_  
Possible Side Effects \_\_\_\_\_  
Directions \_\_\_\_\_  
Emergency conditions for administration in absence of health personnel \_\_\_\_\_  
Describe any reason that would prevent this child from self-administering medication under adult's supervision in the school setting \_\_\_\_\_  
Other medications student is receiving \_\_\_\_\_  
Time Interval for Re-evaluation \_\_\_\_\_  
Licensed Prescriber \_\_\_\_\_ (Please Print)  
Licensed Prescriber \_\_\_\_\_ (Signature)  
Phone Number \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_  
Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_ Denied \_\_\_\_\_ Date \_\_\_\_\_ Reason for Denial \_\_\_\_\_

Signature of Nurse or Administrator \_\_\_\_\_