

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

In the event that a parent requests that a student take medication (including asthma and/or allergy medication) during the school day, these procedures are to be followed:

1. The form below must be completed by the parent or guardian; **an addendum must also be completed for asthma and allergy medication.**
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 (asthma and epinephrine auto-injector medications are exempt from this restriction).
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 _____ Emergency 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 _____