CHANEY MONGE SCHOOL DISTRICT 88
STUDENT MEDICATION AUTHORIZATION FORM

Student Name _____ Date of Birth _____ Grade _____

When a child requires medication, the primary responsibility for administering such medication rests solely on the parents. In those instances when the doctor has determined that administration during school hours is necessary, the school district endorses the following procedures:

1. Medications are defined as over-the-counter and registered prescription drugs. Only medication necessary to maintain a child in school shall be administered during the school day.
2. The physician will complete the Order for Medication (see below).
3. The parent will complete the Parent's request to Administer Medication (see below).
4. Medication will be in the original container or prescription bottle appropriately labeled by the pharmacist, physician, or manufacturer.
5. Medication will be stored in a safe place.
6. The student must come to the office for his/her medication. The school will strive to assist students in grades K-4 to remember to come to the office to take his/her medication.
7. Administration of medication will be performed by the building nurse. The building administrator will be responsible to perform these duties for the nurse in her absence or may delegate these duties to appropriate staff members.
8. In the event of a field trip the building principal will attempt to make arrangements for the student to receive the prescribed medication. Unless these arrangements cannot be made, the student must forego the field trip.
9. Unless otherwise authorized by administration and/or the building nurse, no student may be in possession of any medication at the start of the school day.
10. All areas of the Authorization Form must be completed each school year or medication will not be administered.
11. Medication that is not picked up by the parent at the end of the school year, will be disposed of in the presence of a witness.
12. Students with Diabetes may need to obtain more detailed information from their healthcare provider. Please check with the building nurse for an additional form.

Order for Medication *to be completed by student's* ***Physician, Physician Assistant, or Advanced Practice RN****:*

Medication Name: _____ Dose: _____ Prescription Date:_____ Frequency: _____

Diagnosis: _____ Possible side effects: _____

Time medication is to be administered or under what circumstances: _____

Time Interval for Reevaluation: _____ Prescription Discontinuation Date: _____

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

Other medications student is receiving? _____

Signature: _____ Date: _____

Physician Name Printed _____ Phone Number: _____

For parents/guardians of students who need to carry Asthma inhalers or Epipens:

I authorize the School District and its employees and agents, to allow my child or ward to self-carry and self-administer possess his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the school district to inform parent(s)/guardians(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30***). Please initial to indicate receipt of this information and authorization for your child to carry and use his/her asthma medication or epinephrine auto-injector. Parent/guardian initials*** _____

Parent's Request to Administer Medication- For all parents/guardians:

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 School District and its employees and agents, in my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above.

I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the child's self-administration of medication.

Parent/guardian Name Printed:_____ Date: _____

Parent/guardian Name Signed: _____ Daytime Phone: _____

CHANEY MONGE SCHOOL DISTRICT 88

MEDICATION ADMINISTRATION RECORD FOR SCHOOL YEAR 2018/2019

BUILDING NURSE TO COMPLETE:

Student Name _____ **Grade** _____

Medication / Dose: _____ **Route** _____ **Frequency** _____

Time medication is to be administered or under what circumstances: _____

_____

Date Medication Received: _____ **Initials:** _____

	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
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Signature: _____ **Initials:** _____ **Signature**_____ **Initials** _____

Signature: _____ **Initials:** _____ **Signature**_____ **Initials** _____

NOTES: _____

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Codes:

X = No School Available **ABS = Absent** **O = No Show** **D = Early Dismissal** **N = None**