2023-2024
FLOSSMOOR SCHOOL DISTRICT 161

AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION

Student Name: _____ School: _____

Birthdate: _____ Grade: _____

IF THIS MEDICATION WILL BE SELF-ADMINISTERED AND CARRIED (INHALERS AND EPI-PENS ONLY), ADDITIONAL FORMS ARE NECESSARY.

PHYSICIAN AUTHORIZATION:

Name of Medication: _____

Dosage: _____

Diagnosis: _____

Frequency/Time of Administration: _____

Intended Effect of Medication: _____

Adverse Effects from Medication: _____

Discontinuation Date: _____

Name of Medication: _____

Dosage: _____

Diagnosis: _____

Frequency/Time of Administration: _____

Intended Effect of Medication: _____

Adverse Effects from Medication: _____

Discontinuation Date: _____

_____ _____

PHYSICIAN'S SIGNATURE **PHYSICIAN'S NAME (Please print)**

_____ _____

PHYSICIAN'S PHONE NUMBER **EMERGENCY NUMBER**

_____ _____

PHYSICIAN'S STAMP **DATE**

PARENT AUTHORIZATION:

I herewith acknowledge 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 Flossmoor School District 161 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Flossmoor School District 161), 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. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Flossmoor School District 161, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Flossmoor School District 161, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication. I understand that it may be necessary for the District's professional staff to communicate with the licensed prescriber and/or my child's physician regarding the above medication, and I grant permission for the communication to take place.

Student's Name (Please print)

Parent/Guardian Name (Please print)

Parent/Guardian Signature Date

Parent/Guardian Address

Parent/Guardian Home Phone Work Phone Cell Phone

School medications are administered following these guidelines:

- Physician and Parent dated authorization to administer the medication.
- The medication must be in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, medication name, directions for use, and the date.
- Annual renewal of authorization and immediate notification, in writing of changes.

Approved by Nurse: _____ Date: _____