MORRISON COMMUNITY UNIT DISTRICT #6

Authorization for Administration of Medication Form

School ❑ Northside elementary ❑ Southside elementary ❑ Jr. High school ❑ High School

TO: PARENT OR GUARDIAN

Our district policy states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to the administration of any medication. Medication prescribed daily, or twice a day, should be administered under the guidance of the parent around school hours. No medication will be given during the school day unless absolutely necessary for the critical health and well being of the student. All medication sent to school must be:

1. In the original prescription bottle or for non-prescription medication in the original manufacturer's package:
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time to be given, name of pharmacy; and
3. Medication should be brought to school by the parent/guardian or other responsible adult.

This medication form must be completed with the medication packaged properly as outlined above or the medication will not be given. Please complete this form and return it to the school nurse. This information is kept confidential. Thank you for your cooperation.

_____ (School Nurse)

INFORMATION OBTAINED FROM PHYSICIAN:

Student-Name_____ Birth date: _____

Name of Medication and Dosage: _____

RouteandTime:_____

PossibleSideEffects:_____

Diagnosis/ReasonforMedication:_____

ApprovalforSelf-Administration _____

(Field trips or medication required at time when nurse is not in the building Self-administration will be: Indicate yes or no under the supervision of voluntary school personnel.)

Approval for student to carry emergency medication (Inhaler/Epi-pen)

_____ (Recommend age 10 years or over only) (Indicate yes or no)

_____ (Physician's Signature) (Date)

_____

(Physician's Name -Please Print) (Phone Number/Fax number)

PARENT AUTHORIZATION AND SIGNATURE I authorize Morrison School district and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school district) to my child this lawfully prescribed medication and any prescribed changes. 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 the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the District and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration of attempts at administration of said medication. I allow the school nurse to discuss this medication and its effects on my child with the prescribing physician or his representative.

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Day-time Phone Number) (Emergency Phone Number)