Triad Community Unit District #2
Troy * Marine * St. Jacob

* Note: medication may not be brought or given at school without authorization from the doctor

REQUEST FOR THE ADMINISTRATION OF MEDICINE

STUDENT'S NAME: _____ Date of Birth: _____

Address: _____ Emergency Phone: _____

School: _____ Grade / Teacher: _____

PART I – LICENSED PRESCRIBER'S AUTHORIZATION

1. Name / type of medication: _____
2. Dosage / amount to be given: _____
3. Route of administration: _____
4. Frequency and time of administration: _____
5. Duration (week, month, indefinite, etc.): _____
6. Diagnosis a) _____
   b) _____
7. Intended effect, and anticipated reaction to medication:
   a) _____
   b) _____
8. Other medication child receives: _____
9. Other requirements: _____
10. Must this medication be administered during school hours in order to allow the student to attend school?
    ☐**Yes** ☐**No**

_____ _____
Licensed Prescriber's Signature *(required)* ***Date Signed***

_____
(printed / typed) Licensed Prescriber's Name

_____ _____ _____
Address ***Phone #*** ***Fax#***

PART II – PARENT'S REQUEST / APPROVAL

I hereby request and grant permission for Triad Community Unit District #2 school nurse or trained personnel to:

(Check which apply)

☐Administer above stated medication to my child
(Medicine kept in nurse office)

☐Allow self-carry of asthma medication
(Requires Asthma Action Plan & original label)

☐Allow the self-carry & self-administration of asthma medication
(Requires an Asthma Action Plan & original label)

☐Allow self-carry epinephrine injector
(Requires Allergy Action Plan & original label)

☐Allow the self-administration of epinephrine injector
(Requires Allergy Action Plan & original label)

I understand that an individual other than a certified school nurse may perform this administration, and I specifically consent to this. I further waive any claims against Triad Community Unit School District #2, members of the Board of Education, its employees, and / or agents arising out of the administration of said medication and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees, and / or agents, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney fees, resulting from or arising out of the administration, or self-administration of medication to my child.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

Parent/Guardian (s) Signature _____ ***Phone #*** _____***Date***_____

School Nurse Signature _____***Date Received***_____