SALT CREEK SCHOOL DISTRICT NO. 48

SERVING THE COMMUNITIES OF ELMHURST ● OAKBROOK TERRACE ● VILLA PARK

Address: *1110 S. Villa Ave., Villa Park, IL. 60181* ***Phone:*** *(630) 279-8400* ***Fax:*** *(630) 279-6167*

MEDICATION PERMISSION FORM

This form must be completed and returned to the school health office. A physician's order is necessary for ANY MEDICATION (over-the-counter, short-term, and long-term). We **CANNOT** and **WILL NOT** administer medication without it.

THE FOLLOWING MUST BE COMPLETED BY THE PARENT/GUARDIAN

Student's Name: ______________________ Grade:______ Teacher:______________ Room #________

Address:______________________________________ Phone:______________________

Birthdate:______________ Other medications the child is taking:______________________________

______ I hereby request and grant permission to the authorized personnel from the above named school district to administer the medication described on this form to my child.

______ I give permission for my child to carry their medication and be responsible for its use, provided the doctor gives consent for the same.

______ I give permission for my child to self-administer their medication when they are on a field trip.

If there are any questions, please contact your child's school nurse.

Note: All medication that is not self-carry must be picked up by a parent/guardian on the last day of school or it will be disposed of.

I indemnify and hold harmless Salt Creek District 48 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of medication or the medication storage by school personnel.

Parent/Guardian Signature: ______________________________ Date: ____________________

Cell Phone: ____________________ Emergency Phone: ____________________ Work Phone: ____________________

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THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN

Physician's Name (please print): ______________________________ Phone Number: ____________________

Physician's Address: ______________________________ Fax Number: ____________________

Condition/Illness: ____

MEDICATION: ____

Dosage:____________________ Time to be given: ____________________ Duration: ______________

Possible Side Effects:____

MEDICATION: ____

Dosage:____________________ Time to be given: ____________________ Duration: ______________

Possible Side Effects:____

______ The above named student may carry and self-administer their medication. I certify that they have been properly trained in its use.

______ The above named student may self-administer their medication on a field trip. I certify that they have been properly trained in its use.

Physician's Signature: ______________________________ Date: ____________________

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IMPORTANT INFORMATION:

1. The medication MUST be brought to school in the original container, clearly labeled with the child's name, medication name, and other pertinent information. Duplicate prescription containers can be obtained from your pharmacist. Over-the-counter medications MUST be brought in the original, unopened container with the seal unbroken. **WE WILL NOT** ADMINISTER ANY MEDICATION SENT TO SCHOOL IN plastic containers, baggies, envelopes, etc.
2. The parent MUST immediately report any changes in prescription or dosage. New doctor's orders must be obtained for each change.
3. Medication permission form MUST be renewed at the beginning of each school year.
4. Medication and permission form will be kept in the Health Office.