ARCOLA CUSD #306

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PHONE: 217-268-4961 FAX: 217-268-4719

STUDENT'S NAME: _____

GRADE: _____ DATE OF BIRTH: _____

The following section is to be completed by the PARENT: I confirm that I am responsible for administering medication to my child. However, in the event that I am unable to do so during the school hours, I hereby authorize Arcola School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described below. 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 Arcola School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the Arcola School District, 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 medication.

- I also understand and will comply with the requirements for sending medication to school in the original and current prescription bottle from the pharmacy which is properly labeled with child's name, name of medication and dosage, instructions for administration, date of prescription, prescribing physician, and name of pharmacy and pharmacist. I understand that it is my responsibility to see that the medication arrives at the school in a safe manner. I also understand that noon/lunch medication is not routinely administered on early dismissal days. I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

_____ _____
Parent/Guardian Signature *Date*

_____ _____/_____/_____
Address *Home Phone/Work Phone/ Cell Phone*

_____ _____/_____
Emergency Contact Person *Phone Numbers*

The following section is to be completed by the **PHYSICIAN**:

NAME OF MEDICATION: _____

DOSAGE: _____ TIME OF ADMINISTRATION AT SCHOOL: _____

DIAGNOSIS for which the medication is required to be given at school: _____

EXPECTED SIDE EFFECTS, if any: _____

- If the medication is an inhaler, please provide the following:
  - KNOWN TRIGGERS: _____
  - PEAK FLOW RANGES/ZONES: _____

If medication is to be given on an "AS NEEDED" basis, how soon can it be repeated? _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name – PLEASE PRINT Phone

_____ _____
Address Fax