Bunker Hill Community School District #8
Phone: 618.585.4831
Fax: 618.585.3123

Authorization For Medications To Be Taken During School Hours And Events

To be completed by the child's parent(s)/guardian(s) every school year.

Student's Name: _____ Birth Date: _____
Address: _____
Home Phone: _____ Emergency Phone: _____
School: _____ Grade: _____ Teacher: _____

To be completed by the student's physician, physician assistant with prescriptive authority or advanced practice RN with prescriptive authority.

Prescriber's Printed Name_____ Office Phone_____

Diagnosis:
Name of Medication:
Dose, Route, Time & Frequency:
Desired Benefits of Medication:
List significant side effects:

May this student self-administer medication: Yes____ No_____

Must this medication be administered during the school day: Yes_____ No_____

Prescriber's Signature_____Date_____

To be completed by student's parent/guardian*:*
By signing below, I agree:

1. 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 Bunker Hill School District and its employees, in my behalf, to administer, or attempt to administer to my child (or to allow my child to self-administer pursuant to State law 105 ILCS 5/22-3, while under the supervision of the employees and agents of the District), 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.**
2. To indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

Parent/Guardian Printed Name_____

Parent/Guardian Signature_____ Date_____