

2019-2020  
FLOSSMOOR SCHOOL DISTRICT 161

PHYSICIAN'S AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF PRESCRIPTION AND OVER-THE-COUNTER MEDICATION FOR OUTDOOR EDUCATION PROGRAM

**PARENT'S SECTION:**

Student Name: \_\_\_\_\_ School: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Weight: \_\_\_\_\_  
Allergies: \_\_\_\_\_

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**PHYSICIAN'S SECTION:** Acetaminophen and Ibuprofen (tablets and liquid) will be administered to students who have the following physician orders completed. Additional space is also provided for other medications that may be necessary. **PARENTS: DO NOT FILL OUT THIS AREA!**

**Name of Medication #1: Acetaminophen**  
**325 mg. Tab or 160 mg/5ml liquid**

**Name of Medication #2: Ibuprofen**  
**200mg. Tab or 100 mg/5ml liquid**

DOSAGE: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

Diagnosis: Fever/pain

Diagnosis: Fever/pain

Freq./Time of Administration: \_\_\_\_\_

Freq./Time of Administration \_\_\_\_\_

Intended Effect of Medication: \_\_\_\_\_

Intended Effect of Medication: \_\_\_\_\_

Adverse Effects from Medication: \_\_\_\_\_

Adverse Effects from Medication: \_\_\_\_\_

Discontinue Date: End of Outdoor Education

Discontinue Date End of Outdoor Education

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**Name of Medication #3:** \_\_\_\_\_ **Name of Medication #4:** \_\_\_\_\_

DOSAGE: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Freq./Time of Administration: \_\_\_\_\_

Freq./Time of Administration: \_\_\_\_\_

Intended Effect of Medication: \_\_\_\_\_

Intended Effect of Medication: \_\_\_\_\_

Adverse Effects from Medication: \_\_\_\_\_

Adverse Effects of Medication: \_\_\_\_\_

Discontinue Date: \_\_\_\_\_

Discontinue Date: \_\_\_\_\_

\_\_\_\_\_  
Physician's name, please print

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Phone Number

**If your child requires more than 4 medications, please obtain additional forms from the Health Office at school.**

**PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

**RETURN THIS FORM WHEN YOU HAVE THE PHYSICIAN'S AUTHORIZATION COMPLETED**

I herewith acknowledge 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 Flossmoor School District 161 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Flossmoor School District 161), 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. 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 Flossmoor School District 161, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Flossmoor School District 161, 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 said medication. I understand that it may be necessary for the District's professional staff to communicate with the licensed prescriber and/or my child's physician regarding the above medication, and I grant permission for the communication to take place.

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Student's Name *(Please print)*

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Parent/Guardian Name *(Please print)*

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Parent/Guardian Signature

Date

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Parent/Guardian Address

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Parent/Guardian Home Phone

Work Phone

Cell Phone

School medications are administered following these guidelines:

- Physician and Parent dated authorization to administer the medication.
- The medication must be in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label contains the student name, medication name, directions for use, and the date.
- Annual renewal of authorization and immediate notification, in writing of changes.

Approved by Nurse: \_\_\_\_\_

Date: \_\_\_\_\_