REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

TO BE COMPLETED BY PHYSICIAN

All medications require a new order each school year and whenever changes occur.

Student Name: _____ D.O.B. _____

Diagnosis: _____

Must the following medication be administered during school hours in order to allow the child to attend school? Yes No

Medication: _____ Dose: _____ Route: _____
Time/ Frequency _____
Special Instructions:_____
Intended effect of medication: _____
Side effects of medication: _____
Date to start:_____ Date to discontinue: _____
Other medication the student is currently taking:_____
_____

Physician's name (please print) : _____Date: _____
Physician's signature: _____ Phone number: _____
Physician's address: _____Emergency number: _____

The following applies to emergency medication only (i.e. Inhalers, epi-pens, glucose tabs)

May the student administer his/her own emergency medication? Yes No
May the student carry emergency medication on his/her person? Yes No

I certify that the above named student has been instructed in the use and self administration of the medication above, and am requesting he/she be allowed to take the medication during school hours. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects or use of the medication. He/she is capable of using the medication independently.

Physician Signature: _____ Date: _____

I hereby confirm that I am primarily responsible for administering medication to my child. I hereby authorize Southwester Community Unit School District No. 9 and its employees and agents, in my behalf and stead, to administer or to attempt to administer prescribed medication to my child. I allow my child to self-administer, lawfully prescribed medication if his/her physician gives written authorization. *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 agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to employees and agents from and against any and all claims, damages, causes of action or injuries incurred or resulting from administration of said medication.

Parent's Signature: _____Date: _____