Mannheim School District 83

10401 West Grand Avenue
Franklin Park, IL 60131

Authorization to Administer Medication

A doctor must complete this form. Doctor and parents or guardian must sign this form.

1. Name of Student: _____
2. Date of Birth: _____
3. Name of Physician: _____

   Address: _____

   Phone Number: _____

   Emergency Phone Number: _____
4. Name of Medication/Generic Name: _____
5. Diagnosis or condition for which medication is being administered: _____

   _____

   _____
6. Reason to why medication needs to be given during school hours: _____

   _____

   _____
7. Date of Prescription: _____
8. Dosage: _____
9. Method and Route in which to be administered: _____
10. Frequency and Time to administer: _____
11. Date to discontinue: _____
12. Intended effect of medication: _____
13. Possible side effects of medication, that needs to be observed of student:

    _____

    _____

14. Under health office school staff supervision, student may self-administer medication. The student must provide medication name and dose information. Health office staff must verify this information with the information on the medication container and the medication order. The student should then verify medication container as their own. The District 83 health office staff must observe student measure and drink/swallow required dose, the health office staff can then return medication to its ~~proper storage location and log that medication was given.~~

15. Emergency conditions in which the medication can be administered, including instructions on how

to administer, by a certified member of district staff if health office staff is not available to administer, medical personnel, or by the student:

_____

_____

_____

16. Other medication that student is currently taking: _____

_____

17. Next re-evaluation date: _____

Certified Prescriber

_____ _____

Signature and Title of Prescriber Date

Parent or Guardian:

I give permission to Mannheim School District 83 and its employees to administer/supervise the described medications in accordance to the regulations of the School District 83 who governs the Administration of Medicine in the School District.

_____ _____

Signature of Parent/Guardian Date

Phone Number: _____

Emergency Phone Number: _____

Approved by the District 83 Nurse to begin administration on _____

_____ _____

Signature of District 83 Nurse Date