West Dixmoor/Harvey School District 147

Authorization and Permission for Administration of Medication

(a separate sheet is required for each medication)

Name of Student _____ Birthdate _____

City _____ Zip _____ Home/Cell phone _____

Date: _____ School: _____

PHYSICIAN AUTHORIZATION:

Medication/Health Care Treatment _____ Dosage _____ Time to be administered _____

Intended effect of this medication _____ Other medications student is taking _____

Expected side effects, if any _____

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects.

Administration instructions

_____

_____

Phone Number of Physician _____ Signature of Physician _____ Date _____

Address of Physician _____ Print Name of Physician _____ Date _____

Parental Authorization for Administration of Medication

Student Name: _____ Date of Birth: _____

The following guidelines shall apply to the self-administration of a student's asthma inhaler / epinephrine auto injection medication:

- Physician / Prescriber signed, dated authorization to administer the medication, the name and purpose of the medication, the prescribed dosage and time for administration, and any special related information
- Parent/Guardian signed dated authorization to administer the medication
- The medication is in the original labeled container as dispensed or the manufacturer's labeled container
- The medication label contains the student name, name of the medication directions for use and date
- Annual review of authorization and immediate notification of changes, in writing, from the physician
- School District WHD147 and its employees and agents incur no liability, except for willful and wanton conduct as a result of any injury arising from the self-administration of medication by the student.

Parental Authorization:

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so I hereby authorize School District WHD147 and its employees and agents, on behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer, while under supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described by the physician's order. 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 School District, its employees and agents arising of the administration of said medication. In addition, I agree to hold harmless and indemnify the 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 said medication.

Parent/Guardian signature: _____ **Date:** _____

Home/Cell Phone: _____

Parent/Guardian signature: _____ **Date:** _____

Home/ Cell Phone: _____

Additional information

_____

_____

_____