BETHALTO SCHOOL HEALTH SERVICES CUSD #8
SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME: ___________________________________ BIRTHDATE: _________________

ADDRESS: ____

TELEPHONE:_________________________ EMERGENCY TELEPHONE: ____________________

SCHOOL: _______________________________________ GRADE: ___________________________

I, ____________________________________ , parent/guardian of ___________________________ , here with 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 Bethalto CUSD #8 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 the School 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 certified 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 out 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's Signature Date

Medication must be brought to school in the original container appropriately labeled by the pharmacy. The school assumes no responsibility if medicine is sent to school with the child.

TO BE COMPLETED BY THE STUDENT' S PHYSICIAN

TYPE OF DISEASE OR ILLNESS:____

NAME OF MEDICATION: ____

DOSAGE: ____ TIME: ______________________________

DURATION OF ADMINISTRATION: ____

IS THIS MEDICATION ABSOLUTELY NECESSARY FOR THE CRITICAL HEALTH AND WELL-BEING OF THE STUDENT DURING REGULAR SCHOOL HOURS AND/OR DURING SCHOOL RELATED ACTIVITIES/?

YES___ NO___ ***INCLUDING FIELD TRIPS***? YES___ NO___

THIS MEDICATION SHOULD CAUSE (desired benefits): ____

SIDE EFFECTS OF THE MEDICATION ARE: ____

May student self-administer inhaler/Epi-pen under supervision of Health Service personnel or designate?
(A self-administration form must be completed on back of form) (Please circle) YES / NO

____

Physician's name printed Physician's signature

____

Address Date

____

Telephone Number Emergency Telephone Number

BETHALTO SCHOOL HEALTH SERVICES CUSD #8

Request for Self-Administration of Inhaler / Epi-pen

____

Name of Student   Birthdate

____

Address   Telephone Number

TO:

Principal: _____________________________
School: _____________________________

The above named student has ____
(Name of Disease or Syndrome)

I am requesting the above named student be allowed to self-administer the following medication during school hours / school related activities.

____

Name of Medication Type of Medication (inhaler / Epi-pen)

____

Dosage Time(s) to be given

____

Possible Side Affects

I certify that __________________________________ has been instructed in the use and self-administration
(Name of Student)

of ____
(Name of Medication)

He / she understands the need for the medication, and the necessity to report to school personnel any unusual side effects.   He / she is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

___________________________________ ____

Physicians's name printed   Physician's signature Date

___________________________________ ____

Address   Telephone Number / EmergencyTelephone Number