

NORTH BOONE COMMUNITY UNIT SCHOOL DISTRICT #200

Authorization for the Administration of Medication

Name of Student _____ Date of Birth _____
Address _____ Telephone _____
_____ Grade _____
School _____

PHYSICIAN'S STATEMENT

I hereby request that the above named student take the following medication, as it is medically necessary during school hours.

This medication authorization is valid for the 20__ to 20__ school year.

Name of Medication _____
Dosage/route _____
Time/Frequency of administration _____
Duration (week, month, etc.) _____
Diagnosis Requiring Medication _____
Possible Side Effects _____
Other Medication Student is receiving _____

I have instructed the above named student and parent/guardian in the use and administration of this medication. He/ she understands the necessity to report any unusual side effects.

PHYSICIAN SIGNATURE: _____ Date _____

Printed name _____ Phone _____

PARENT REQUEST/APPROVAL

I hereby request the school nurse administer or certified school personnel supervise the self-administration of the above-prescribed medication to my child. I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration by the pupil.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

FOR PARENT(S)/GUARDIAN(S) OF STUDENTS WITH ASTHMA/LIFE THREATENING ALLERGY

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his/her asthma medication/EPI Pen (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities. "I take full responsibility for the appropriate use of the medication by the student named above. I understand that distribution to any other student will result in suspension and possible expulsion of my child or ward."

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

HIGH SCHOOL ONLY (grades 9-12)

With a written doctor order and parent permission on file in the nurse's office, students may carry their own non-prescription medication and self-administer without going to the nurse's office if the parent signs the following statement. Students requiring pain medication routinely should consult their parent, physician or school nurse. "I take full responsibility for the appropriate use of the medication by the student named above and I want my student to carry the medication with him/her. I understand that distribution to any other student will result in suspension and possible expulsion of my child or ward."

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____