AUTHORIZATION OF THE ADMINISTRATION/ SELF ADMINISTRATION OF MEDICATION

IMMANUEL LUTHERAN SCHOOL

1310 N Frolic Ave
Waukegan, IL 60085

____________________________ __________ ________ ______________________

Student's Name (First, Last) *D.O.B* *Grade* *Teacher*

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TO BE COMPLETED BY THE APPROPRIATELY STATE LICENSED HEALTH CARE PROVIDER

PLEASE NOTE: Only those medicines which of absolute necessity must be given during school hours will be given at school: q day, b.i.d.., and t.i.d.. medicines will NOT be given at school.

____________________________ ____________ ______________ ___________

Medication *Dosage* *Time of Admin.* *Route*

Prescribed for (diagnosis)

____

Reason for Medication (intended effects)

____

Reaction and/or Side Effects: ( ) Yes (please describe below) ( ) None anticipated

____

This student is both capable and responsible for self-administering this medication:
( ) No ( ) Yes - Supervised ( ) Yes - Unsupervised

For Asthma Inhaler or Epi-Pen only:

This student may carry this medication: ( ) No ( ) Yes - if yes then complete the following

I certify that _______________________________ has been instructed
Name of Student (print)

in the use and self-administration of _______________________________________.
Name of Medication

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If permitted to self-administer this 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 the medication independently.

Other prescription and non-prescription medications this child receives are:

____

I may be reached at ______________________________ in the event of a reaction or emergency.

Phone Number

____ ______________________

Signature of Medical Provider *Date*

____ ______________________

Printed name of Medical Provider *Medical Provider Phone #*

____ ______________________

Medical Provider Address *Medical Provider Fax #*

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TO BE COMPLETED BY THE PARENT/GUARDIAN

I give permission for my child___________________________________ to receive the above mentioned medication as prescribed. I understand that my signature on the form constitutes a waiver by me to the school, its employees and agents for administering or supervising the administration of this medicine from liability for untoward reactions when the medicine is administered in accord with the prescribing State-Licensed health provider's instructions. I additionally agree to indemnify and hold harmless the school, its employees and agents for any claims arising from the administration of medication by or to my child in accordance with my authorization, except those that are based upon willful misconduct. I consent to the sharing of information between the prescribing health care provider and the school nurse, and an executed authorization for is attached hereto and incorporated herein by reference.

______________________________________ ______________________ ________________

Parent/Guardian Signature *Daytime Phone #* *Date*