

AMBOY CUSD #272 SCHOOL MEDICATION AUTHORIZATION FORM

District 272's school policy states that medications that are to be given by a nurse/health aide or designated person to a student only upon written request of a parent.

All medication sent to school must be in a properly labeled pharmacy bottle with the name of the student, doctor, name of medication, dosage, and time to be given.

Parent/Guardian and Physician must complete this form and return to the school. A new form must be completed every year and kept in the nurse office. If more than one medication is prescribed, please complete another form. This information is kept confidential between physician, parent, teacher, and school/health aide. This is essential for the safety of your child.

To be completed by Parent/Guardian:

Student's Name _____ **Birthdate** _____

Address _____

Home Phone _____ **Emergency Phone** _____

School _____ **Grade** _____ **Teacher** _____

To be completed the student's physician, physician assistant or advanced nurse practitioner:

Physician's Printed Name _____

Office Address _____ **Office Phone** _____

Medication Name _____

Medication's Purpose _____

Dosage _____ **Frequency** _____

Time medication to be administered or under what circumstances _____

Prescription date _____ **Discontinuation date** _____

Diagnosis requiring medication _____

Is it necessary for this medication to be administered during the school day? ____ Yes ____ No

Expected side effects, if any _____

Time interval for re-evaluation _____

Other medications student is receiving _____

Physician's signature _____ **Date** _____

For All Parents/Guardians:

By signing below, I agree 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 Amboy School District and its employees and agents, in my behalf, to administer or attempt to administer to my child 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 school nurse and specifically consent to such practices and I agree to indemnify and hold harmless the Amboy School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian signature _____ **Date** _____