Waukegan Public Schools
Office of School Health Services

Staff Members Trained in _____

Medication Administration:_____

AUTHORIZATION OF THE ADMINISTRATION/ SELF ADMINISTRATION OF MEDICATION

_____ _____ _____ _____
Student's Name | Date of Birth | Grade/Room | Teacher

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 unless specifically requested.*

_____ _____ _____ _____
Medication | Dosage | Time of Administration | 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 complete the following

I certify that _____has been instructed in the use and self-administration
Name of Student
of_____
Name of Medication
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 this medication independently.

Other prescription and non-prescription medications this child receives are: _____
I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

_____ _____ _____
Signature of Medical Provider | Date | Printed Name of Medical Provider

_____
Medical Provider Phone # | Medical Provider Fax #

Medical Provider Address_____
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TO BE COMPLETED BY PARENT / GUARDIAN:

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

_____ _____ _____
Date | Parent/Guardian's signature | Daytime Phone #

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