

**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