COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Road * Arlington Heights, IL 60005
847-593-4300

Meds Picked Up By: _____
Date: _____

SCHOOL MEDICATION AUTHORIZATION

When a child requires medication or health services during school hours or school-related activities, it is necessary for the school to have on file in the student's health record, authorizations from the parent/guardian and the licensed health care provider. The school should be notified in writing of any change in medication. This request must be renewed at the beginning of each school year.

Student's Name _____ Birth Date _____

Address _____

School _____ Grade _____ Teacher _____

I hereby confirm my primary responsibility to administer medication and provide health services 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 Community Consolidated School District 59 and its employees and agents, in 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 and health services in the manner described above. **I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS AND DELIVERY OF HEALTH SERVICES TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES.** I further acknowledge and agree that, when the lawfully prescribed medication or health services are so administered, or attempted to be administered, I waive any claim I might have against the School District, its employees and agents arising out of the administration of said medication or services. 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, attempts at administration of said medication or health services or the child's self-administration of medication.

_____ _____ _____
Signature – Parent/Guardian | Printed Name | Date

Phone: Home (_____) _____ Work (_____) _____

PHYSICIAN'S ORDER

Diagnosis for which medication is given: _____

Name of Medicine	
Form	Dose
Reason for medication and intended effect	
If medicine to be given DAILY, at what time?	
If medicine to be given "WHEN NEEDED," describe indications:	
How soon can medication be repeated?	
Is child authorized to medicate herself/himself?	
List significant side effects:	
Length of time this treatment is recommended:	
Are there special requirements (refrigeration of medication, medication to be given before or after lunch, etc.)?	
Do you require a report from the school as to the effects of the medication?	

_____ _____ _____
Signature – Physician, Physician Assistant, or Advanced Practice Registered Nurse | Printed Name | Date

_____ (_____) _____
Address | Telephone Number

H-25 (Rev. 5/08) Distribution: health file