Manteno Community Unit District No. 5

OVER THE COUNTER MEDICATION

Parent/Physician Request for Administration of Medication at School

THIS MEDICATION ADMINISTRATION FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR: _____

Dear Parent/Legal Guardian:

- **Non-prescription** medication **must** be in the **original container** with the label intact. Medication received in Bags will **not** be accepted.
- **A Prescriber's signature is required**
- **An adult must bring the medication to the school.**
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

Student's Name: _____Birth Date: _____ School/Grade: _____

----------Health Care Provider Authorization----------

Student's Physician: _____

Medication: _____Dose:_____

Time to be administered: _____ Dates to be administered: _____

Condition for which medication is required: _____

Has the student ever taken this medication before ☐ YES ☐ NO

Medication Allergies: ☐ No Known Medication Allergies ☐ Allergic to: _____

Special Instructions/Precautions/Side Effects of medication on the student: _____

_____

The student has been instructed in the use and self-administration of the medication, and is authorized to self-administer the medication with appropriate supervision: ☐ YES ☐ NO

Prescribers Signature: _____ Date: _____ Telephone: _____

Prescribers Printed Name and Title: _____ Fax: _____

----------Parent/Guardian Authorization----------

By signing below, I agree as follows: The information set forth above is correct and I am in agreement with the information. I 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 the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of an employee/agent 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 school nurse and specifically consent to such practices.** I acknowledge that the School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of the medication or the student's self-administration of the medication. I agree to indemnify and hold harmless the School District and its employees and agents against any and all claims, except claims based on willful and wanton conduct, arising out of the administration of the medication or the student's self-administration of the medication.

Parent/Guardian Signature: _____ Date: _____

Home/Cell Phone: _____ Work phone: _____ Email: _____

To Be Completed by School

Date form was received by school:_____ Received by:_____