LAKE PARK SCHOOL DISTRICT 108
DAILY & AS NEEDED MEDICATION AUTHORIZATION FORM

STUDENT NAME: _____ BIRTHDATE: _____

CAMPUS: _____ ID NUMBER: _____ PHONE NUMBER: _____

EMERGENCY CONTACT NAME: _____

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Our district policy and guidance from the Illinois State Board of Education states that all prescription and nonprescription medications that are given during the school hours must have this form completed prior to the administration of any medication. No medication will be given during the school day unless absolutely necessary for the critical health and wellbeing of the student. By signing below, I agree that I am primarily responsible for administering medication to my child. However, I authorize Lake Park High School District 108, and its employees and agents, on my behalf and in my stead, to administer medication to my child or to allow my child to self-administer medication while under the supervision of the employees and agents of the school district, lawfully prescribed medication in the manner listed above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I also give my permission for Lake Park High School District 108 to share all pertinent medical information about my child with school staff members involved with my child. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the school district, its employees and agents, arising out of said medication. In addition, I agree to indemnify and hold harmless the school district, its employees and agents, jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct.

All medications must be:

1) **In the original prescription container or original manufacturer's package if non-prescription;**
2) **Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, the time to be given, name of the pharmacy, and**
3) **Medication should be brought to school by the parent or other responsible adult. Controlled medications must be counted in the presence and with the signatures of the parent/guardian and two staff members.**

This medication from must be completed with the medication packaged properly as outlined above or the medication will not be given.

Name of medication, dosage, route & time: _____

Parent/Guardian Signature: _____ **Date:** _____

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TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER/PHYSICIAN

Student Name: _____ DOB: _____

Name of Medication and Dosage: _____

Route and Time: _____

Time/Circumstances when medication should be administered: _____

Diagnosis/Reason for Medication: _____

Side Effects: _____

Other medications student is taking: _____

Start Date: _____ End Date: _____

_____ _____

Physician Phone Physician Print Name

_____ _____

Physician Address Physician Signature Date

Updated 1/9/19