ADMINISTERING MEDICINE AT SCHOOL

Riverview CCSD#2

This form must be completed by your physician when a student needs to take *PRESCRIPTION AND NON-PRESCRIPTION* medication at school.

DOCTOR'S REQUEST FOR ADMINISTERING MEDICINE AT SCHOOL

STUDENT'S NAME:_____ DOB:_____ GRADE:_____

ADDRESS:_____ SCHOOL: Riverview CCSD#2

PARENT/GUARDIAN:_____

SPECIFIC DIAGNOSIS:_____

It is required that this medication be administered during school hours for the comfort of this child.

Name of Medication:_____

Dosage:_____ Special Directions:_____

Possible Side Effects:_____

_____ _____

Physicians Printed Name Physicians Signature

_____ _____

Office Address Office Phone

_____

Date

GUARDIAN REQUEST FOR ADMINISTERING NON-PRESCRIPTION MEDICINE AT SCHOOL

These non-prescription medications may be administered at Riverview CCSD #2. All over the counter medications including cough drops must be provided by the parent/guardian.

MEDICINES & DOSAGE:_____

STUDENT NAME:_____

_____ _____

Parent Signature Physicians Signature

For only parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector:

I authorize the School District and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30). ***If you agree please initial:*** _____

Parent Authorization:

I hereby 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 (name of School District) and its employees and agents, on 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 or agent of the School District, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that 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 Districts, 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 Signature	Date Signed
Parent Phone Number	Parent Emergency Phone Number

Additional Information:

Cross-references: PRESS 7:270, *Administering Medicines to Students;* 7:270-AP, *Dispensing Medication;* 7:270-E, *School Medication Authorization*