

**TO: PARENT OR GUARDIAN**

Our school policy states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to the administration of any medication. No medication will be given unless absolutely necessary for the critical health and well-being of the student.

All medication sent to school must be:

1. In the original prescription bottle or for non-prescription medication in the original manufacturers package.
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time to be given, name of pharmacy.

Please sign this form and return it to the school nurse. This information is kept confidential. Thank you for your cooperation.

\_\_\_\_\_  
(School Nurse)

**INFORMATION OBTAINED FROM PHYSICIAN:**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Name of Medication and Dosage: \_\_\_\_\_  
Possible Side Effects: \_\_\_\_\_  
Diagnosis/Reason for Medication: \_\_\_\_\_

**Approval for Self-Administration**

(Field trips or medication required at time when nurse is not in the building)

Self-administration will be under the supervision of voluntary school personnel. \_\_\_\_\_ Indicate Yes or No

**Approval for student to carry emergency medication (Inhaler/Epi-Pen)**

\_\_\_\_\_ Indicate Yes or No

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Physician's Name - Please Print)

\_\_\_\_\_  
(Phone Number/Fax Number)

**PARENT AUTHORIZATION AND SIGNATURE:**

I authorize DeKalb Community Unit School District 428 and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school district) to my child this lawfully prescribed medication and any prescribed changes.

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 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 the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the District and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration or attempts at administration of said medication.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Daytime Phone Number)

\_\_\_\_\_  
(Emergency Phone Number)