BETHEL GRADE SCHOOL

District 82
Phone 618/244-8095

1201 Bethel Road
Mt. Vernon, IL 62864

SCHOOL MEDICATION AUTHORIZATION

PART 1

Part 1 MUST be completed and signed by the child's physician or prescriber:

Child's Name _____

Name of Medication _____

Dosage_____ Frequency_____ Time to be given_____

Date of Prescription_____ Date of Order_____

Discontinuance Date_____

Diagnosis Requiring Medication_____

Intended effect of this Medication_____

Significant side effects (if any)_____

Time interval for Re-evaluation_____

Other medication child is receiving_____

This medication must be administered during the school day (between the hours of 8:00 AM and 3:00 PM) in order for the child to attend school.

_____YES _____NO

This medication may be administered by non-medically trained teachers.

_____YES _____NO

This child may self-medicate him/her self.

_____YES _____NO

_____

PHYSICIAN'S SIGNATURE (required) DATE

Medication must be brought to school by the parent in a container appropriately labeled by the pharmacy or the physician/prescriber. Medication orders should be renewed annually for long-term medications and any changes should be reported to the school nurse in writing.

PART 2

Part 2 must be completed by the child's parents. PLEASE PRINT.

Child's name_____ Birth Date_____

Address_____ Home Phone_____

School_____ Teacher_____

Allergies to Medications_____

Parent's Emergency Phone Number_____

Physician/Prescriber's Name_____

Physician/Prescriber's Address_____

Physician/Prescriber's Office and Emergency Numbers_____

I hereby confirm 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 Bethel Grade School 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 the employees and agents of the school district), lawfully prescribed medication in the manner described in Part 1 of this form.

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 specifically consent to such practices.

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 the administration of said medication. 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 of attempts at administration of said medication.

As the parent of legal guardian of the above named child, I hereby grant my permission to Bethel Grade School to exchange information concerning the child's medical condition with named physician for the purpose of safe and legal administration of medication. It is understood that this authorization may be withdrawn in writing at any time.

Parent Signature (required)_____ Date_____

FOR OFFICE USE ONLY

Person Obtaining Permission by Phone_____ Date_____

Person Granting Permission by Phone_____ Date_____