CHANNAHON SCHOOL DISTRICT #17
MEDICATION ADMINISTRATION CONSENT

Dear Parent or Guardian:
In accordance with district #17 policy, **WE ARE UNABLE TO COMPLY WITH ANY REQUESTS TO ADMINISTER MEDICATION UNLESS THIS FORM HAS BEEN COMPLETED BY BOTH THE PARENT AND THE PHYSICIAN.**
Upon receipt of the completed form, we will follow the indicated procedures in administration of medication to your child.
Thank you for your cooperation. _____
School Nurse

_____
Child's Name D.O.B. School

Physician's Order for Administration of Medication at School: Date: _____
I have determined that the following medication must be taken during school hours.

Medication: _____

Dose and Frequency: _____ Child's Weight: _____
Route of Administration: PO _____ INHALE _____ INJECTION _____ OTHER_____

Purpose for Medication: _____Possible Side Effects: _____

Other medications the child is taking: _____

Doctor's Printed Name: _____ Address: _____
Fax Number: _____
Doctor's Signature: _____ Phone Number: _____

Physician Request for Self -Administration of Inhalers or Emergency Medication: I certify that the above named student has been instructed in the use and self-administration of the above-mentioned drug. He/she understands the need for the medication, and the necessity to report to school personnel after using the emergency medication and if he/she has any unusual side effects. He/she is capable of carrying his/her medication on their person and using it independently.

SELF-ADMINISTRATION OF INHALER/EMERGENCY MEDICATION_____ (please initial)

Parent Consent for Administration of Medication at School:

I confirm that I have read and agree to the Medication Policy. I further confirm that I am primarily responsible for medication administration 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 Channahon School District #17 and its employees and agents in my behalf, to administer or attempt to administer to my child, or to allow my child to self-administer above mentioned medication ordered by Dr. _____

Time of Administration: _____ (medication will be administered at lunch time unless a different time is indicated)

Pharmacy Name, Address, Phone: _____

I can be reached at the following number(s) in the event of a problem or question: Home _____
Work _____ Cell _____ Pager _____

I understand that my child's medication will be administered/supervised, and he/she is responsible and aware of this.

Parent/Guardian Signature _____ Date _____