

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.** (Exception; asthma inhalers and Epi-Pens)

Upon receipt of the completed form, we will follow the indicated procedures in administration of medication to your child.

Thank you for your cooperation.

Karen Peters, R.N.; Julie Wright, R.N.
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: _____ Time to Administer: _____

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 my physician. I further waive any claims that I might have against the school district, it's employees and agents arising out of the administration of said medication. I also agree to defend and hold harmless the school district and its employees and agents as to any claims of damage resulting from the administration or attempts at administration or student self administration of medication.

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 _____