# Arlington Heights School District 25 Health Services Department

## School Medication Authorization Form

To be completed by the child's parent(s)/guardian(s) and physician. A new form must be completed every school year. Forms will be maintained in the child's health record.

Student's Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

School:_____ Grade: _____ Teacher: _____

*To be completed by student's physician, physician's assistant, or advanced practice RN.*

Physician's Printed Name: _____ Phone Number: _____

Medication Name, dosage (required):_____

Purpose: _____

Route and frequency (required):_____

Time medication to be administered and circumstances: _____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Diagnosis requiring medication: _____

Possible side effects: _____

Is it necessary for this medication to be administered during the school day? _____yes _____ no
Other medications student is receiving:_____

_____ _____
Physician's Signature Date

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By signing below, I agree 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 the School District and its employees and agents, on behalf of myself, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than a school nurse and specifically consent to such practices. I indemnify and hold harmless the School District and its employees and agents against any claims, except a claim of willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____ _____
Parent/Guardian Signature Date

Revised 01/2017