Burbank School District # 111
Parent Authorization for Medication

Student ______________________Birthdate __________ Grade _____

Address ____

Home Phone__________________EmergencyPhone_______________

Medication____

Dosage _______________________Frequency ___________________

Prescribing Physician_______________________________________

Pharmacy Name ____________________ Phone # ________________

I acknowledge and agree that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize Burbank School District #111 and its employees, on my behalf, to allow my child to self-administer such medication while under the supervision of the employees of Burbank School District #111, 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 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 of the administration and/or self 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 or attempts at administration of said medication.*

I understand it is my responsibility to maintain an adequate supply of my child's medication and any related supplies and to bring such medication and supplies to the school in the original container labeled by the pharmacy. I further understand it is my responsibility to provide the school with a new physician's authorization when there is a change in my child's medication or dosage and at the start of each school year. I hereby give my consent for the school district to contact the prescribing physician regarding any questions pertaining to the health condition or medication.

_________________________________ ____________________

Signature of Parent/Guardian Date

*I understand that the school district, its employees and agents incur no liability, except for willful and wanton misconduct as a result of any injury arising from the administration or self-administration of said medication.

Burbank School District # 111
Physician Authorization for Medication
School Year _______

The Illinois State Board of Education and the Illinois Department of Human Services have developed guidelines for the administration of medication during the school hours. Please complete the information below.

Student ______________________________ Birthdate _____________

Medication ____

Dosage ______________________ Frequency_____________________

Type of medication (tablet, liquid, or inhaler)_____________________

Diagnosis ____

Intended effect ____

Possible side effects ____

Other medication student is taking ______________________________

Student's next appointment for reevaluation ______________________

Special considerations ____

All medication administered in school must be in an original container properly labeled by a pharmacist.

_________________________________ ______________

Doctor's Signature Date

Doctor's Name ____

Phone # ____

Date/Time medication started: ___________________________________

Date/Time medication discontinued: ______________________________

Reason: ____

(5/11)