MUNDELEIN ELEMENTARY DISTRICT #75 • 470 N. LAKE STREET • MUNDELEIN • ILLINOIS • 60060

PRESCRIPTION/OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

This order is valid only for the current school year _____-_____ (Including Summer Session)

OR

Start Date: ____/____/____ ***to*** Stop Date: ____/____/____

A new medication administration form must be completed at the beginning of each school year, for each medication and each time there is a change in dosage, or time of administration of a medication.

** Medication form must be completed fully in order for staff to administer required medication.*

Name:	*Birth Date:*	*Grade/Teacher:*

HEALTH CARE PROVIDER AUTHORIZATION

Diagnosis or Condition for which medication is being administered:

Name of Medication	**Dosage:**	**Route:**
	☐ _____mg ☐ 2 PUFFS ☐ Other _____	☐ ORAL ☐ INHALATION ☐ OTHER _____

Time of Administration:	***If PRN, Frequency:***

Additional Instructions:

Specific Instructions for Inhaler:

Administer inhaler for symptoms such as: *Coughing, audible wheezing, c/o tightness in chest, complaint of shortness of breath, or other* _____.

☐ *Student is competent to **self-carry** inhaler or Epinephrine*	☐ *Student is competent to **administer** inhaler or Epinephrine*

Specific Instructions for Antihistamine:

☐ Immediately following known ingestion of/or contact with _____

☐ Administer for mild allergy symptoms which include:

NOSE: *itchy, runny nose, sneezing* SKIN: *few localized hives, mild itching* GI: *mild nausea; discomfort*

Other Symptoms (specify):

Possible Medication Side Effects:

☐ None expected ☐ Specify: _____

Health care provider stamp

Health Care Provider's Name/Title (Please Print):

Telephone: Fax:

Address:

Health Care Provider's Signature: ***Date:***

NURSE'S OFFICE ONLY: *Medication Expiration date: _____/_____, _____/_____*

PARENT/GUARDIAN AUTHORIZATION

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 my behalf, to administer or to attempt to administer to my child (or 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 above.

In the event that a nurse is not available, my child may be asked to self-administer his/her own medications. In addition, he/she understands the need for the medication and the necessity to report to school personnel unusual side effects. He/ she is capable of using this medication independently.

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct arising out of the administration or the child's self-administration.

Parent/Guardian Signature: ***Date:***

Primary Contact Phone:	*Secondary phone:*

For only parents/ guardians of students who need to carry and self-administer asthma medications or an EpiPen:

I authorize the School District and its employees and agents to allow my child or ward to possess and self-administer his or her asthma medication and/or epinephrine auto-injector: (1) While in school, (2) while at school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. In addition, he/she understands the need for the medication and the necessity to report to school personnel unusual side effects. He/she is capable of using this medication independently. We recommend that you provide an additional dose of the medication to be kept in the school nurse's office in the event that your student forgets or loses the medication. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and its agents,incur no liability, except for willful and wanton conduct, as a result of an injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30), ***If you agree please initial:***_____ Parent(s)/guardian(s)