Bellwood School District 88
640 Eastern Ave, Bellwood, IL 60104

Authorization and Permission for Administration of Medication

Student's name: _____ Birthday: _____ School: _____

Address: _____ Phone: _____

I request that School District 88 employees administer or supervise the self-administration of medication in accordance with the guidelines established by The State Board of Education and the Department of Human Services. I understand that it may be necessary for someone other than the school nurse to supervise my child self administering his/her medication and I specifically consent to this. I hereby release School District 88 and any of its agents, employees and administrators (hereinafter, the District) from any liabilities for any injury or harm which is suffered by my child as a result of the District's agreement to honor this request. I agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal/medical fees, from the District whenever the District has acted in accordance with the information provided by my child's primary care provider. I was provided with a copy of the District's Guidelines for the Administration of Medication at School for Parents.
Medication must be delivered to the school by a responsible adult, in a properly labeled pharmacy bottle.
I give permission for the School Nurse to contact the primary care provider regarding the administration of this medication.

_____

Parent/Guardian Signature Date

_____

Home number Cell number Work number

TO BE COMPLETED BY THE STUDENT'S PRIMARY CARE PROVIDER: Only one (1) medication per form

I have determined that the following medication must be administered during school hours. I understand that the student may be supervised by unlicensed school personnel self-administering his/her medication in the school health office.

Diagnosis _____ Medication _____

Route of administration _____ Dosage _____ Time _____

Reason for medication _____

Side effects _____

Re-evaluation date _____ Discontinuation date _____

Other medications taken by student _____

In the event of a reaction to the medication school staff should do the following: _____

_____

_____

In case of emergency I can be reached at the number below:

_____

Physician's Name Physicians Signature Date

_____

Address Telephone number

This authorization form is valid for one year from date of signature. Any change in medication requires a new form