

**Alden-Hebron
Community Consolidated Unit Schools**

DISTRICT NO. 19 – HEBRON, ILLINOIS 60034

ELEMENTARY SCHOOL
11915 Price Road
815-648-2442

DISTRICT ADMINISTRATIVE OFFICE
11915 Price Road
815-648-2442
Fax: 815-648-2339

MIDDLE/HIGH SCHOOL
9604 Illinois Street
815-648-2442

Authorization and Permission for Administration of Medication

Student's Name _____ Birthdate: _____

Grade: _____ School Year: _____ Emergency Phone: _____

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School medications and health care services are administered following these guidelines:

- *Physician/Prescriber signed dated authorization to administer the medication.*
 - *Parent signed, dated authorization to administer the medication.*
 - *The medication is in the original labeled container as dispensed or the manufacturer's labeled container.*
 - *The medication label contains the student name, name of the medication, directions for use and date.*
 - *All medication taken at school must be taken to the nurse's office.*
 - *Annual renewal of authorization and immediate notification, in writing, of changes.*
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Physician Authorization:

Medication/Health Care Treatment	Dosage	Time to be administered
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Intended effect of this medication	Expected side effects, if any
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Other medications student is taking _____

May student self-administer medication under supervision of Health Service personnel or designate?

(A student self-administration form must be completed) (Please circle) **YES / NO**

May carry inhaler? **(A student self-administration form must be completed)** (Please circle) **YES / NO**

May carry Epi-pen? **(A student self-administration form must be completed)** (Please circle) **YES / NO**

Administration instructions: _____

Discontinue/Re-Evaluate/Follow-up Date (circle one)	Prescriber's Signature
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Prescriber's Printed Name	Prescriber's Emergency Phone#	Date signed
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Prescriber's Address

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Parental Authorization:

I herewith acknowledge 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 **Alden-Hebron School District #19** and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child, _____, (or to 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. I acknowledge that it may be necessary for the administration of medications to my child to 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 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.

Parent's Signature

Date

Parent's Address

Home Phone

Cell Phone

Business Phone

Additional Information
