LINCOLN-WAY HIGH SCHOOL DISTRICT 210 – MEDICATION AUTHORIZATION FORM

Please return this form to the school nurse

STUDENT NAME: ______________________________

STUDENT ID#______________________ GRADE______ DATE OF BIRTH ______________

Physician's orders: *(To be filled out by the attending Doctor -please print)*

Medication #1. ______________________ Dosage ________ Route _______ Time to be given ________

Reason for prescribing medication________________ possible side effects of medication ________________

Medication #2. ______________________ Dosage ________ Route_______ Time to be given ________

Reason for prescribing medication________________ possible side effects of medication ________________

Medication #3. ______________________ Dosage ________ Route_______ Time to be given ________

*Reason for prescribing medication*________________ Possible side effects of medication ________________

Medication #4. ______________________ Dosage ________ Route ________ Time to be given ______

Reason for prescribing medication________________ possible side effects of medication ________________

Physician's signature ______________________________ Date ________________

Address ______________________________ Phone Number ________________

Parent Authorization: ***To be completed by parent/guardian:***

I/We hereby grant my permission for District 210 to administer to______________________ the above named medication as prescribed by the above physician. I /We agree to provide medication in a properly labeled bottle/container from the pharmacy. The medication will be kept in the nurse's office, and the student will report to the nurse's office to receive the prescribed medication.

Please check this box if this medication was prescribed for Band Camp or a Lincoln-Way District 210 outside activity ☐

Parent/Guardian signature: ______________________________

Address ______________________________

Home phone ________________ Work phone________________ Cell phone ____________ Date ________

In the event it is necessary that the student SELF-ADMINISTER their asthma medication/epi-pen injector at school and or INDEPENDENTLY manage their diabetes in school, I/we waive any claims/damages/causes of action/injuries that might arise out of ________________ medication self-administration/diabetes self-management. I/We agree that the school district and its employees/agents are to incur no liability as a result of any injury/personal harm arising from the student's medication self-administration/diabetes self-management.

Parent/Guardian Signature ______________________________ Date ________________

Parent/Guardian Signature ______________________________ Date ________________

Nurse: ***(To be completed by school nurse)***

Medication #1. ____________ Dosage ____________ Route ________ Administration time ______________

Prescription # ________ Pharmacy Name ____________ Physician Name ______________

Medication #2. ____________ Dosage ____________ Route ________ Administration time ______________

Prescription # ________ Pharmacy Name ____________ Physician Name ______________

Medication #3. ____________ Dosage ____________ Route ________ Administration time ______________

Prescription # ________ Pharmacy Name ____________ Physician Name ______________

Medication #4. ____________ Dosage ____________ Route ________ Administration time ______________

Prescription # ________ Pharmacy Name ____________ Physician Name ______________

Other Medication needed ______________________________

School Nurse Signature ______________________________ Date ________________