1109 North Eighth Street 618-283-5151

Vandalia Community Unit School District #203

SCHOOL MEDICATION AUTHORIZATION FORM

Our district policy and guidance from Illinois State Board of Education states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to administration. No medication will be given during the school day unless absolutely necessary for the critical health and well-being of the student. All medication must be in the original prescription container or manufacturer's package and properly labeled with the student's prescribing information.

Student Name _________________________________ **Date of Birth** _______________________________

Grade ____ **Teacher/Homeroom** ________________________

Emergency Name and Phone Number ____

I hereby authorize Vandalia School District #203 and its employees and agents, in my behalf and stead, 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, a lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medications to be performed by an individual other than a school nurse, i.e. school administrator, and I consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so 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 of said medication.

____ ___________________________________

Parent/Guardian Signature **Date**

TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

Name of Medication ____

Dosage ____ **Route**_____________________

Duration of Administration _______________________________________ **Time** _____________________

Diagnosis ____

Side Effects to be alert to: ____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? _______ Yes ________ No

Must this medication be kept with the child at all times? _______ Yes ________ No

Is the child allowed to self carry and self administer this medication (EpiPen, inhaler, insulin)? _______Yes _______ No

PHYSICIAN NAME (PRINT) ________________________________ **DATE** _________________________________

PHYSICIAN SIGNATURE____

PHYSICIAN ADDRESS____________________________________ **PHONE** ______________________________