**MEDICATION CONSENT FORM**
**Herscher Community Unit School District 2**

PO Box 504, 501 N Main, Herscher IL 60941 District Office Phone: 815-426-2162/Fax: 815-426-2872

**Bonfield Grade School**
**Herscher Intermediate School**

**Herscher High School**
**Limestone Middle School**

## ----------PRESCRIPTION & OVER THE COUNTER MEDICATION----------

**Parent/Physician Request for Administration of Medication at School**

**Dear Parent/Legal Guardian:**

- Prescription medication must be in a container labeled by the pharmacist or prescriber, with student's name, name of medication, dose, and correct time to be given. Non-prescription medication must be in original container and a prescriber's signature is required.
- An adult must bring the medication to the school.
- The school nurse (RN) will call the prescriber, if a question arises about the child and/or the child's medication.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed. Letters will be sent home at the end of the school year.**

**Student's Name: _____Birth Date: _____ School/Grade: _____**

**Health Care Provider Authorization**

**Medication: _____ Diagnosis requiring medication: _____**
**Order Date: _____ Discontinuation Date: _____**
**Dose: _____ Route: _____ Time to be administered: _____**
**Has student taken before: _____ Intended Effects: _____ Allergies: _____**
**Side Effects: ☐ None expected: ☐ Specify: _____**
**Other medications student is receiving, special instructions, precautions: _____**
**Is it necessary for this medication to be administered during the school day: ☐ YES ☐ NO**
**The student has been instructed in the use and self-administration of the medication, and is authorized to self-administer the medication with appropriate supervision: ☐ YES ☐ NO**

**PRESCRIBERS SIGNATURE: _____ Date: _____ Telephone: _____**
**PRESCRIBERS PRINTED NAME AND TITLE: _____Fax:_____**

## ----------Parent/Guardian Authorization----------

By signing below, I agree as follows: The information set forth above is correct and I am in agreement with the information. I 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 the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of an employee/agent 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 acknowledge that the School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of the medication or the student's self-administration of the medication. I agree to indemnify and hold harmless the School District and its employees and agents against any and all claims, except claims based on willful and wanton conduct, arising out of the administration of the medication or the student's self-administration of the medication.

**Parent/Guardian Signature: _____ Date: _____**
**Home/Cell Phone: _____ Work phone: _____ email: _____**

## Epi Pen-Self Carry/Self Administration of Emergency Medication Authorization/Approval

This student is at risk of anaphylaxis and is authorized to self-carry and self-administer an epinephrine auto-injector.

**Prescriber's authorization**: _____
Signature Date

**Parent/Guardian's authorization**: _____
Signature Date

| To Be Completed by School | | |
|---|---|---|
| **Date form was received by school:_____** | **School Year:_____** | **Received by:_____** |