HEALTH SERVICES – BELVIDERE COMMUNITY SCHOOLS
Authorization for the Administration of Medication

Name of Student_________________________________ Date of Birth__________
Address _________________________________ Telephone __________
_________________________________ Grade __________
School _________________________________

PHYSICIAN'S STATEMENT

I hereby request that the above named student take the following medication, as it is medically necessary during school hours.

Name of Medication ____
Dosage/route ____
Time/Frequency of administration ____
Duration (week, month, etc.) ____
Diagnosis Requiring Medication ____
Possible Side Effects ____
Other Medication Student is receiving ____

I have instructed the above named student in the use and administration of this medication. He/ she understands the necessity to report any unusual side effects.

PHYSICIAN SIGNATURE: ___________________________Date______________
Printed name ____________________________ Phone______________________

PARENT REQUEST/APPROVAL

I hereby request the school nurse administer or certified school personnel supervise the self-administration of the above-prescribed medication to my child. I indemnify and hold harmless the school district and its' employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration by the pupil.

PARENT/GUARDIAN SIGNATURE: ______________________ DATE: ________________

FOR PARENT(S)/GUARDIAN(S) OF STUDENTS WITH ASTHMA/LIFE THREATENING ALLERGY

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his/her asthma medication/EPI Pen (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities. "I take full responsibility for the appropriate use of the medication by the student named above. I understand that distribution to any other student will result in suspension and possible expulsion of my child."

PARENT/GUARDIAN SIGNATURE: ________________________DATE: ________________

HIGH SCHOOL ONLY (grades 9-12)

With a written doctor order and parent permission on file in the nurse's office, students may carry their own non-prescription medication and self administer without going to the nurse's office if the parent signs the following statement. Students requiring pain medication routinely should consult their parent, physician or school nurse. "I take full responsibility for the appropriate use of the medication by the student named above and I want my student to carry the medication with him/her. I understand that distribution to any other student will result in suspension and possible expulsion of my child."

PARENT/GUARDIAN SIGNATURE: __________________________DATE: _______________