



Cary Community Consolidated  
School District 26  
ADMINISTRATION CENTER

2115 Crystal Lake Road • Cary, Illinois 60013 • 847-639-7788

## Authorization for Administration of Medication at School

### Parent Permission

Date \_\_\_\_\_

Student Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Medication \_\_\_\_\_

Dose \_\_\_\_\_

Time \_\_\_\_\_

Subject to doctor's approval, I request that my child be allowed to self-administer the medication

Yes  No

Subject to doctor's approval, I request that the School Nurse or authorized school personnel administer the medication.

Yes  No

*I hereby request that the above medication be administered at school during school hours.*

Parent/Guardian Signature \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

With regards to self-administration of medications, I acknowledge that the school district, its employees and agents incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by my child.

In addition, I indemnify and hold harmless the school district, its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Note: In our effort to ensure the safety of all students, any student in possession of any medication, pills or other drug look-alike substances without proper authorization at school will be subject to suspension. All medication must be registered with the nurse.



## Authorization for Administration of Medication at School

### Physician Request

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Medication \_\_\_\_\_

Dose \_\_\_\_\_ Time \_\_\_\_\_

Duration: From \_\_\_\_\_ To \_\_\_\_\_  
Date Date

Indicate why medication is required during regular school hours in order to maintain the continued attendance of this student.

\_\_\_\_\_

Condition requiring medication \_\_\_\_\_

Desired benefits of the medication \_\_\_\_\_

Indicate any expected reactions \_\_\_\_\_

Indicate how school personnel can determine if student experiences an adverse reaction

\_\_\_\_\_

Indicate steps for school personnel to follow in case student experiences an adverse reaction to the medication.

\_\_\_\_\_

This medication may be self-administered.  Yes  No

This medication may be administered by school personnel other than the nurse.  Yes  No

\*The student should retain the prescribed medication on his/her person at all times due to need for immediate administration in the event of an emergency.  Yes  No

*I hereby request that the above prescribed medication be administered during school hours and certify that it is absolutely medically necessary to maintain the continued attendance of the student.*

Signature of physician or other licensed health care provider who is authorized to prescribe medication under Illinois Law. \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

\*Medications prescribed on an "as needed" basis will be considered to be administered on an emergency basis.