AUTHORIZATION FOR MEDICATION ADMINISTRATION

Dear Parent/Guardian or Health Care Provider,

School District 271 Health Services is committed to the mission of providing the best care possible for all our students in order to support their education. Please provide the following medical accommodation(s) at school for:

- ☐ Student Name: ______________________________ Date of Birth: __________
- ☐ Medical Diagnosis: ____

(This can include: asthma, diabetes, allergies, seizures, food allergies/intolerances, care following an accident, encopresis/enuresis, etc.)

Medication(s) necessary: (may include Antibiotics, Epi-pen, Insulin, Inhaler, medication for ADD/ADHD, etc.)

1. Name/Type of Medication	
2. Dosage/Amount to be given	
3. Frequency	
4. Time(s) to be Administered	
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2. Dosage/Amount to be given	
3. Frequency	
4. Time(s) to be Administered	

- ☐ Please add any additional information/suggestions that may be helpful in the school setting:

____

____

(Include dietary considerations, blood sugar checks, changes in classroom seating, extra time for testing/assignments based on medical need or procedures, etc.)

Due to increasing requests for care of students with various medical conditions, it is necessary to obtain this information before setting up a plan of care for students based on a medical diagnosis and/or administering prescription medications at school. It is not our intent to "limit" students in any way, but to provide the accommodation(s) they will need in order to succeed in school.

- ☐ Health Care Provider Name: ______________________ MD office/Phone: ______________
- ☐ Health Care Provider Signature: ______________________ Date: ______________

(Only needed for Prescription Medication)

- ☐ Parent/Guardian Signature: ______________________ Date: ______________

(Your signature authorizes confidential information to be exchanged between School Health Services and your child's health care provider.)

- ☐ School Nurse/School: ______________________ Phone: ______________

STUDENT'S NAME: ______________________________ **Date of Birth:** ______________

All controlled medications MUST have documentation of having been counted each time a new bottle is brought in. Controlled medications must be counted by the school staff member receiving the meds and witnessed by a parent each time a controlled medication is brought in. The number of pills will be documented on this form, name of medication, number of pills, date and signature of both staff member and parent/guardian.
Controlled medications include but are not limited to: Dexedrine, adderall, cylert, ritalin, concerta, methylin, codeine, oxycontin, percocet, valium, xanax, empirin, fiorinal, tylenol with codeine, darvon, diastat, lomotil, lorcet, lortab, vicodin, norco, dilaudid, talwin.

Documentation of medication brought to school for student:

Name of Med: ____________ Amount (#): ________ Date: ______ Staff: ________ Parent: ______
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Name of Med: ____________ Amount (#): ________ Date: ______ Staff: ________ Parent: ______

Medication picked up from school by parent:

Name of Med: ____________ Amount (#): ________ Date: ______ Staff: ________ Parent: ______

Medication wasted/destroyed:

Name of Med: ____________ Amount (#) ________ Date: ______ Staff: ________ Witness: ______