

*Education that inspires…Opportunities for all*

**GURNEE SCHOOL DISTRICT 56**

*3706 Florida Avenue • Gurnee, IL 60031 • 847-336-0800 • www.d56.org*

**Annual Medication Authorization Form**

**for Prescription and/or Over the Counter Non-Prescription Medications**

**School Year \_\_\_\_\_\_\_\_\_**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Grade/Rm: \_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Taken at Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attention Parents: Medication will not be administered without this form.**

***To be Completed by Parent or Legal Guardian***

Authorization: Permission is hereby granted to Gurnee School District 56 to release information/to obtain information from the individual/organization as identified below for the purpose of the medication(s) requested. In signing this form, I understand the following provisions:

1. I am under no obligation to sign.
2. Failure to sign will mean that the information will not be requested or released. One consequence for refusing to release this information includes, but may not be limited to, a failure on the part of the receiving party to fully appreciate, or be aware of, the client’s/student’s pertinent history in planning and providing service/treatment.
3. I have the right to revoke this authorization at any time by written request (except for information previously disclosed).
4. I have the right to inspect and copy the information disclosed.
5. This form authorizes the release of the information specified within one year from date of signature.

The medication needs to be sent to school in an appropriately labeled bottle by the pharmacy. Notify the school in writing if the medication is discontinued. Obtain a written doctors order if the medication dosage is changed. A parent must bring the medication to the school nurse. For the safety of your child, the School District retains the right to reject the administration of medication if compliance with these guidelines is not followed. I have read and understand the above medication authorization.

I give permission for my child to receive the medication(s) by assigned school personnel as directed by the physician.

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***To be Completed by Physician Only***

**Attention Physician: Your signature indicates that these medications are necessary during school attendance.**

Medication given for diagnosis of: 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intended effect of medication: 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Dosage/Frequency** | **Time and Dose to be given at School** | **Duration/End Date** | **Possible Side Effects Anticipated** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

**Signature of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_