Education that inspires…Opportunities for all

GURNEE SCHOOL DISTRICT 56

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

Medical Authorization Form
For Prescription and/or Over-the-Counter Medications
School Year _____

Child's Name: _____ DOB: _____ Grade: _____ **SCHOOL**: _____
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:

a) I am under no obligation to sign.
b) 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.
c) I have the right to revoke this authorization at any time by written request (except for information previously disclosed).
d) I have the right to inspect and copy the information disclosed.
e) 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 #: _____

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: _____

Office Stamp

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School Year _____

Parent/Guardian Authorization for Self-Administration of Rescue Inhaler/Epi-Pen

Student _____ D.O.B. _____
School _____ Grade _____

I am requesting that this student carry and use the medication as prescribed on the medication prescription label and/or per physician directions. I have submitted the medication with the prescription label that contains my child's name, the name of the medication, the prescribed dose, the time at which or circumstances under which the medication is to be administered. I am requesting that my child carry and use the medication while under the supervision of school personnel.

He/she is capable of using this medication independently, understands the time or specific circumstances under which the medication is to be used and the necessity to report to school personnel any unusual side effects. I understand, according to school policy, if this poses a danger to him/herself or other students, the medication will be kept in the Health Office and I will be notified. Gurnee School District 56 employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student, regardless of whether authorization is given by the parent or the physician.

_____ _____ _____
Parent/Guardian Signature **Date** **Daytime Phone Number**

Physician Authorization for Self-Administration of Epi-Pen or Rescue Inhaler

I am requesting that this student carry and use the medication as prescribed on the medication permission form (see other side) while under the supervision of school personnel. I certify that this student has been instructed in the use and self-administration of the _____ **Epi-Pe**n _____**Rescue Inhaler**
He/she is capable of using this medication independently, understands the time or specific circumstances under which the medication is to be used and the necessity to report to school personnel any unusual side effects. I understand according to school policy that the medication will be removed from the student if it poses a danger to him/herself or others.

_____ _____ _____
Physician Signature **Date** **Daytime Phone Number**