School Medication Authorization Form

R13

Township High School District 113

All Medication Must be Properly Labeled

☐ **Deerfield High School**
1959 N. Waukegan Rd. Deerfield, IL 60015
Phone: 224/632/3200; Fax: 224/632/3206

☐ **Highland Park High School**
433 Vine Ave. Highland Park, IL 60035
Phone: 224/765/2200; Fax: 224/765/2708

Student Name: _____
Last First

Grade: ◯ Fr. ◯ So. ◯ Jr. ◯ Sr Date of Birth: _____

Start Date: _____ Discontinuation Date: _____

Diagnosis/Reason: _____

Medication: _____

Daily: _____ PRN: _____ Emergency: _____

1. Strength: _____ Dosage: _____ Frequency: _____ Time: _____
2. Route of administering: _____
3. Side effects student should be observed for: _____

   _____
4. Other medication student is receiving: _____

Health Services stocks the Over the Counter medications below. Please provide medication if your student requires a different form than tablets.

❑ **Ibuprofen (Advil)** 200 mg, 1-2 tabs, every 6 hours, as needed

❑ **Acetaminophen (Tylenol)** 325 mg, 1-2 tabs, every 4-6 hours, as needed

❑ **Acetaminophen Extra Strength (Tylenol Extra Strength)** 500 mg, 1-2 tabs, every 6 hours, as needed

❑ **Diphenhydramine (Benadryl)** 25 mg 1-2 tabs, every 4-6 hours, as needed

I hereby request and grant permission for Township High School District 113 school nurse or any registered nurse approved by the District, or in the case of an emergency, another staff member, administer medication to my student according to the above instructions. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the storage, administration, or self-administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents,

either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication, except for willful and wanton conduct.

For Asthma Medication/Epinephrine Auto-Injectors/Diabetes Medication/Emergency Seizure Medication* Only: I consent to my student's possession and unsupervised self-administration of (circle applicable medication) asthma medication/epinephrine auto-injectors/diabetes medication/ emergency seizure medication: _____yes _____ no.

** A student must be authorized to self-administer insulin in accordance with the student's individual health care plan, Section 504 plan, or diabetes care plan*.

_____ Parent/ Guardian signature

_____ Licensed Prescriber signature

_____ Emergency No. of Parent/Guardian

_____ Address/Phone

Date _____

Date _____

<u>Medication cannot be given unless this form is completed in its entirety and signed by the licensed prescriber and parent/guardian</u>

**The licensed prescriber signature is not required for a student's self-administration of asthma inhalers.*

REV. 12/2022