

**LABORATORY SCHOOLS  
SCHOOL MEDICATION AUTHORIZATION FORM**

If a student must receive prescription or non-prescription medication at school, the following written request completed and signed by both the licensed prescriber (i.e. Physician, NP, Dentist or Podiatrist), and the parent or guardian must be on file at the school. The appropriate form is available at WEBSITE or can be requested from the School Nurse. You must have the doctor's portion completed or a prescription for every prescription or non-prescription medication except sunscreen (for sunscreen, please complete the Sunscreen Permission Form).

All prescription medication must be in the original container labeled by the pharmacist or licensed prescriber. Local pharmacies will provide an extra prescription bottle upon request. The label must include: Name of Student, Name of Medication, Dosage, Time to be Taken, Prescriber's Name, and Date

Non-prescription medication (i.e. Tylenol, ibuprofen, etc.) must be in the original labeled container with the student's name affixed to the container.

All medications (prescription and nonprescription) must be kept locked in the nurse's office or in the school office when not in use. **Students are not allowed to carry any medication on their person.** The only exception is inhalers and EpiPens, which the student may carry, ONLY if a medication form authorizing the student to self-administer is on file (a backup dose should also be provided to the school nurse).

Unless ordered for a short term, all requests for self-administration of medication will expire at the end of the school year. If the parent/guardian does not pick up any unused medication after notification, the School Nurse shall dispose of the medication. No medication will be provided by the school.

**TO BE COMPLETED BY LICENSED PRESCRIBER:**

Student's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Time to be given in school \_\_\_\_\_

Date of prescription: \_\_\_\_\_ Date of Order \_\_\_\_\_ Discontinuation Date \_\_\_\_\_

If the medication is an EpiPen or for treatment of asthma, can it be self-administered? Yes \_\_\_\_\_ No \_\_\_\_\_

Special Instructions \_\_\_\_\_  
\_\_\_\_\_

Diagnosis requiring medication \_\_\_\_\_

Intended effect of this medication \_\_\_\_\_

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medication condition? \_\_\_\_\_ Side effects, if any \_\_\_\_\_

Time interval for re-evaluation \_\_\_\_\_ Other medications student is receiving \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's name (please print) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**TO BE COMPLETED BY PARENT OR GUARDIAN:**

I confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize University High School/Thomas Metcalf School and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of University High School/Thomas Metcalf School), the above listed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices.** I further acknowledge and agree that, when the medication listed above is administered or is attempted to be administered, I waive any claims I might have against the The Board of Trustees of Illinois State University on behalf of its Laboratory Schools, its employees and agents arising out of the administration of said medication and agree to hold harmless and indemnify against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Name (please print) \_\_\_\_\_

Address \_\_\_\_\_

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