Dear Parents/Guardians:

Prescription medications and over the counter (OTC) medications may not be dispensed by school officials until the following guidelines have been met, and the paper work received.

Physicians are encouraged to schedule doses of medications around school schedules so that it will not be necessary for the school district to be placed in the business of dispensing medications. Medication administration is normally not a function of education, but if it becomes necessary for a student to take medication/treatment at school then the following guidelines must be followed:

1. Provide building principal (or nurse) with completed medication forms signed and dated by physician and the parent/guardian.
2. Prescription medication must be brought to school in the container in which it was purchased. The label must include student's name, medication name/dosage, administration route/any other directions, date prescribed, number of refills, physician's name, pharmacy name, address, phone number, name or initials of pharmacist.
3. Over the counter medication (OTC) or non-prescription medication must be received in the original container in which it was purchased. The student name must be affixed to the container as well as the date sent.
4. No medication, whether prescribed or over the counter, may be given to a student without a physician's order as well as signed parental authorization and permission according to school code, and state law.
5. No medication, whether prescribed or over the counter, may be carried by the student unless the physician has ordered the medication to be self-administered and carried by the student and the proper medication and permission forms have been completed and signed.
6. The school does not assume responsibility for medication, which is not delivered to and kept in the school office or other secure designated area.
7. Parents must notify school of medication/treatment changes or discontinuation.
8. This request must be renewed annually.

SHERRARD COMMUNITY UNIT SCHOOL DISTRICT #200
REQUEST FOR THE ADMINISTRATION OF MEDICINE OR TREATMENT

Student's Name_____ Grade/Teacher_____

Parent/Guardian's Name_____Emergency phone #_____

Physician's Request for Administering Medication at School/School Events

Medicine or Treatment_____ Diagnosis_____

Dosage and directions for administration at school/school events_____
_____Discontinuation Date_____

Possible Side Effects_____

May child self-administer this medication at school under supervision of Health Service personnel or designate _____? (If yes, the attached student self-administration form must be completed.)

Physician's signature and stamp_____

Physician's phone number_____ Date Signed_____

Parent's Request for Administering Medication at School/School Events
Parental Authorization:

I herewith acknowledge 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 Sherrard School District #200 and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child, _____(or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed 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 lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the Sherrard School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the school District, its employees and agents, either jointly or severally, from and 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's Signature_____ Date_____
Home Phone_____ Work Phone_____
Parent's address_____

Request For Self-Administration of Medication or Treatment

Sherrard CUSD #200

_____ _____

Name of Student Birth date

_____ _____

Address Parent Signature Date

_____ _____

City ZIP Telephone Number

The following information is to be completed by the PHYSICIAN:

_____

Medication or treatment to be self-administered

_____

Dosage/time interval/route of administration at school/school events

Side effects_____

Diagnosis requiring medication_____

Anticipated discontinuation date_____

I certify that _____has been instructed in the use and self-administration of _____

(name of medication /treatment)

He/she understands the need for the medication/treatment, and the necessity to report to school personnel any unusual side effects. He/she is capable of administering this medication/treatment independently.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

_____ _____ _____

Physician's phone number Physician's signature and stamp Date