APPENDIX K
MEDICATION FORMS
Authorization and Permission for Self-Administration of Medication
Prescription and Non-prescription

PLEASE NOTE: BSS personnel may not administer or supervise the administration of medications to students unless the following conditions are met:

1) Parents submit this form from a physician prescribing the medicine with the dosage to be given.
2) Physician/Prescriber signed dated authorization to administer the medication
3) Parent signed, dated authorization to administer the medication.
4) Annual renewal of authorization and immediate notification, in writing, of changes.
5) Parents provide the medicine in the ORIGINAL container with the pharmacist's label attached.
6) All medications are to be brought to the office at the beginning of the school day where they will be stored in a locked unit. Medication requiring refrigeration will be handled accordingly. No medications should be in student possession throughout the day unless the form on the back of this sheet as been completed.
7) Standard treatment for all cuts, scrapes, etc. will be to clean the affected area with soap and water and to apply a bandage when necessary.

_____ _____ ___ ___/___/___ ___/___/___

Student's Name (Last) **(First)** **(M)** **Birthdate** **Date**

Physician Authorization:

_____ _____ _____

Medication/Health Care Treatment Dosage Time to be administered

_____ _____

Intended effect of this medication Expected side effects, if any

_____

Other medications student is taking

_____

May student self-administer medication under supervision of Health Service personnel or designate? (Please circle) YES / NO

I certify that _____ has been instructed in the use and self-administration of the medication(s) described above.

Administration instructions:

_____

_____

_____

Discontinue/Re-Evaluate/Follow-up Date

_____ ___/___/___ _____

Prescriber's Signature Date Printed name of Presciber

_____ _____

Prescriber's Emergency Phone # Prescriber's Address

Parental Authorization

I hereby 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 Blessed Sacrament of the Diocese of Peoria and its employees and agents, on 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 Blessed Sacrament), 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 Blessed Sacrament School, its employees and agents arising out of the administration of said medications. In addition I agree to hold harmless and indemnify Blessed Sacrament, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action of injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____

Parent's Signature Home Phone

_____ _____

Parent's Address Business Phone

_____

Date

If your child has asthma or another chronic illness and you want him/her to carry medications for self-administration, please complete the section below.

Parent Agreement for Child to Carry Asthma Medication(s) or Medications for Chronic Illness

I give permission for my child, _____, to carry the medications described below. I will notify the school of changes in medication of my child's condition.

Name of Medication	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature: _____

Date: ____/____/____

2/24/03