THIS SIDE FOR SCHOOL USE ONLY ** THIS SIDE FOR SCHOOL USE ONLY ** THIS SIDE FOR SCHOOL USE ONLY ** THIS SIDE FOR SCHOOL USE ONLY

STUDENT'S NAME_________________________________ **DOB**____________ **GRADE**_________

MEDICATION ____

DOSAGE ____

TIME OF ADMINISTRATION _______________________________

START DATE ____________________ **D/C DATE**______________

MEDICATION/DOSAGE CHANGES ________________________

____

SCHOOL YEAR

MONTH	DAY																														
AUG	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
SEP	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
OCT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NOV	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DEC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
FEB	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MAR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
APR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JUN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

COMMENTS:

KEY: *MEDICATION GIVEN AS ORDERED* /

MEDICATION NOT GIVEN DUE TO: **O** = out of med **X** = absent **Δ** = no show

Medication given on school days as ordered by physician unless otherwise noted. Physician authorization attached.

Signed by: initials _______ signature __________________________________

initials _______ signature __________________________________

initials _______ signature __________________________________

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PAWNEE COMMUNITY UNIT SCHOOL DISTRICT #11

PHONE: 625-2231 FAX: 625-2251

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The following section is to be completed by the **PARENT**:

STUDENT'S NAME ____ __________ ______________

Grade **Date of Birth**

I confirm that I am responsible for administering medication to my child. However, in the event that I am unable to do so during school hours, I hereby authorize Pawnee School District #11 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described below. 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 Pawnee School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the Pawnee 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 medication.
***I also understand and will comply with the requirements for sending medication to school in the original and current prescription bottle from the pharmacy which is properly labeled with child's name, name of medication and dosage, instructions for administration, date of prescription, prescribing physician, and name of pharmacy and pharmacist. I understand that it is my responsibility to see that the medication arrives at school in a safe manner. I also understand that noon/lunch medication is not routinely administered on 12:00 dismissal days, nor is morning doses of medication given at school and medication is not sent on field trips**.** I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

____ ____________________

Parent/Guardian Signature Date

____ __________/__________

Address Home Ph Work Ph/Cell

____ ____________________

Emergency Contact Person Phone

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The following section is to be completed by the **PHYSICIAN**:

NAME OF MEDICATION ____

DOSAGE ______________________________ TIME OF ADMINISTRATION AT SCHOOL ____________

DIAGNOSIS for which the medication is required to be given at school ______________________

EXPECTED SIDE EFFECTS, if any: ____

****If the medication is an inhaler, please provide the following:***

KNOWN TRIGGERS ____

PEAK FLOW RANGES/ZONES ____

If the medication is to be given on an "as needed" basis, how soon it can be repeated? : ______________

____ ____________________

Physician's Signature Date

____ ____________________

Physician's Name – please print Phone

____ ____________________

Address Fax