



3401 Gunderson Ave., Berwyn, Illinois 60402  
Phone: 708-795-2300 Fax: 708-795-2317 Online: www.bsd100.org

# Berwyn South School District 100

## MEDICATION PERMISSION FORM

This form must be returned to the school health office. A physician's order is necessary for ANY MEDICATION, over-the-counter, short-term and long-term medication. We will not administer the medication prior to receiving this permission form completed and signed by your physician.

### THE FOLLOWING MUST BE COMPLETED BY THE PARENT/GUARDIAN:

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Other medications the child is taking \_\_\_\_\_

\_\_\_\_\_ I hereby request and grant permission to the authorized personnel from the above-named school to administer the medication described on this form to my child.

\_\_\_\_\_ I give permission for my child to carry his/her inhaler and to be responsible in its use, provided the doctor gives consent for same.

\_\_\_\_\_ I give permission for my child to self-administer his/her medication when s/he is on a field trip.

If there are any questions, please contact your child's school nurse.

All medication that is not self-carry needs to be picked up by a parent/guardian on the last day or it will be disposed of.

I indemnify and hold harmless District 44 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of medication or the medication storage by school personnel.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Emergency Phone (\_\_\_\_) \_\_\_\_\_

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### THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

Physician's Name (please print) \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Illness/Condition Involved \_\_\_\_\_

MEDICATION \_\_\_\_\_

Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_ Duration of the dosage \_\_\_\_\_

MEDICATION \_\_\_\_\_

Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_ Duration of the Dosage \_\_\_\_\_ Possible Side

Effects \_\_\_\_\_

\_\_\_\_\_ The above-named student may self-administer his/her medication on a field trip. I certify that s/he has been properly instructed in its use.

\_\_\_\_\_ The above-named student may carry and self-administer his/her inhaler. I certify that s/he has been properly instructed in its use.

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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### IMPORTANT INFORMATION

- The medication MUST be brought to school in the original pharmaceutical container, clearly marked with the child's name, medication name and pertinent information. Duplicate prescription containers can be obtained from your pharmacist. Over-the-counter medication MUST be brought in its original, unopened container with the seal unbroken. **We will not administer any medication sent to school in plastic containers, baggies, envelopes, etc.**
1. The parent must report immediately any changes in prescription or dosage. New doctor's orders must be obtained for each change.
  2. Medication permission must be renewed at the beginning of each school year.
  3. Medication and permission form will be kept in the Health Office.