Rantoul Township High School
District # 193
Phone: 217-892-6123 RN's Office
Fax: 217-892-4442 or 217-892-6181

Student Medication Authorization Form

(Required when a student needs to take prescription and non-prescription medication at school.)

_____	_____/_____/_____	_____	_____
Student's Name	**Birth Date**	**Grade**	**Date**

School medication and health care services are administered following these guidelines:

1) **Physician.prescriber signed and dated authorization to administer the medication**
2) **Parent/guardian signed and dated authorization to administer the medication**
3) **The medication must be in the original labeled container as dispensed or the manufacturer's labeled container**
4) **The medication label must contain the student's name, name of the medication and directions for use and date.**
5) **Annual renewal of authorization and immediate notification of changes is required.**

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, PHYSICIAN ASSISTANT, OR ADVANCED PRACTICE REGISTERED NURSE

_____	_____	_____
Medication/Treatment	**Dosage**	**Time to be administered**

_____	_____
Diagnosis	**Side Effect (if any)**

Administration Instructions:
_____

Effective Date:_____ To:_____

Other Medication the Student is Taking _____

May the student self-administer the medication under the supervision of a school nurse or school designee? _____ YES _____ NO

_____	_____	_____
Name of Physician, Physician Assistant or Advanced Practice Nurse	Signature	Date

Office Phone:_____ Address:_____

Please continue to other side

Student Medication Authorization Form

For all Parents/Guardians:

By signing below, I agree 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 Rantoul Township High School and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law while under the supervision of the employee and agents of District #193), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medication to my child be performed by an individual other than a school nurse and specifically consent to such practices,** and I agree to indemnify and hold harmless Rantoul Township High School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the child's self-administration of medication.

_____

Parent/Guardian printed name

_____ _____

Parent/Guardian signature Date signed

_____ _____

Parent/Guardian Phone Number Daytime Emergency Phone Number

Additional Information:

_____

_____

Rantoul Township High School
Distrito #193
Teléfono: 217-892-6123 Enfermería
Fax: 217-892-4442 o 217-892-6181

Student Medication Authorization Form

(Required when a student needs to take prescription and non-prescription medication at school.)

______________________________ ___/___/___ ________ ________
Nombre del Estudiante **Fecha de Nacimiento** **Grado** **Fecha**

Medicamento en la escuela y servicios de atención médica son administrados siguiendo estas pautas:

1) **Autorización para administrar medicamento firmada y con fecha de un médico/prescriptor**
2) **Autorización de Padre/Guardián firmada y con fecha para administrar medicamento**
3) **El medicamento debe estar en su envase original etiquetado como se dispensó o en el envase etiquetado por el fabricante**
4) **La etiqueta del medicamento debe contener el nombre del estudiante, nombre del medicamento e instrucciones de uso con fecha.**
5) **Renovación anual de autorización y notificación inmediata de cambios es requerido.**

- -

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, PHYSICIAN ASSISTANT, OR ADVANCED PRACTICE REGISTERED NURSE

______________________ ______________________ ______________________
Medication/Treatment **Dosage** **Time to be administered**

______________________ ______________________
Dosage **Side Effects (if any)**

Administration Instructions:

____

Effective Date: ______________________ **To:**______________________

Other Medication the Student is Taking______________________

May the student self-administer the medication under the supervision of a school nurse or school designee? ______YES _____NO

______________________________ ______________________ ______________
Name of Physician, Physician Assistant or Advanced Practice Nurse Signature Date

Office Phone:______________________ Address:______________________

Please continue to other side

Formulario de Autorización de Medicamentos del Estudiante

Para todos los Padres/Guardianes:

Al firmar abajo, estoy de acuerdo que yo soy principalmente responsable de administrar medicamento a mi hijo/a. Sin embargo, en el evento que yo no pueda hacerlo o en el evento de una emergencia médica, yo autorizo a Rantoul Township High School y a sus empleadores y agentes, en mi nombre, de administrar o atemptar de administrar a mi hijo/a (o permitir a mi hijo/a de auto administrarse de conformidad a la Ley del Estado bajo la supervisión de un trabajador o agente del Distrito #193), medicamento recetado legalmente en la manera que se describió anteriormente. **Yo reconozco que puede ser necesario que la administración de medicamentos a mi hijo/a sea realizada por un individuo que no sea una enfermera de la escuela y específicamente consiento totales practicas,** y estoy de acuerdo a indemnizar y mantener ofensa a la Escuela Rantoul Township High School y a sus empleadores y agentes contra cualquier reclamo, excepto un reclamo basado en una conducta intencional y arbitraria, que surge de la autoadministración de medicamentos por parte del estudiante.

_____
Firma en molde de Padre/Guardián

_____ _____
Firma de Padre Fecha Firmada

_____ _____
Número de Teléfono del Padre Numero de Telefono de Emergencia

Información Adicional:

_____

_____