ROCKFORD CHRISTIAN SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM

TO: PARENT OR GUARDIAN

Our district policy states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to the administration of any medication. Medication prescribed daily, twice or three times daily should be administered under the guidance of the parent around school hours. No medication will be given during the school day unless absolutely necessary for the critical health and well-being of the student.

All medication sent to school must be:

1. In the original prescription bottle or for non-prescription medication in the original manufacturer's package;
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time to be given, name of pharmacy; and
3. Medication should be brought to school by the parent/guardian or other responsible adult.

This medication form must be completed with the medication package properly as outlines above or the medication **will not be given**. Please complete this form and return it to the school nurse. This information is kept confidential. Thank you for your cooperation.

INFORMATION OBTAINED FROM PHYSICIAN:

Student Name: ____ Birth date: ________________________

Name of Medication: ____

Dosage: ____

Route and Time: ____

Possible Side Effects: ____

Diagnosis/Reason for Medication: ____

Other Medications: ____

___________________________________ ___________________________

(Physician's Signature) (Date)

___________________________________ ___________________________

(Physician's Name – Please Print) (Phone Number/Fax)

PARENT AUTHORIZATION AND SIGNATURE:

I authorize Rockford Christian School and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer while under the supervision of the employees and agents of this school) to my child this lawfully prescribed medication and any prescribed changes. I acknowledge that it 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 school, its employees and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify Rockford Christian School and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration or attempts at administration of said medication. I allow the school nurse to discuss this medication and its effects on my child with the prescribing physician or his representatives. Rockford Christian School, and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the pupil, regardless of whether authorization was given by the physician, physician's assistant or advanced practice registered nurse.

___________________________________ ___________________________

(Parent/Guardian Signature) (Date)

___________________________________ ___________________________

(Day-Time Phone Number) (Emergency Phone Number)