Hawthorn District 73

MEDICATION AUTHORIZATION FORM

- Complete one form for each prescription AND over-the counter medication
- Medications must be provided in original, labeled containers

STUDENT NAME_____

BIRTHDATE _____

GRADE/HOMEROOM _____ SCHOOL_____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

As the parent/guardian of the student listed above, I hereby authorize Hawthorn School District No. 73, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of the school district, 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 the school nurse and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

_____ _____

Parent/Guardian Signature *Date*

❒ This medication must be administered during school hours for the student's health and educational success. If so, student must be responsible for coming to the nurse's office at the scheduled time to take the medication.

A. TO BE COMPLETED BY THE LISCENSED PRESCRIBER (except for a student self-administering asthma medication)

Diagnosis:_____ Name of medication:_____

Dosage:_____ Route of administration:_____

Time/Circumstances when medication should be administered: _____

Side effects:_____

Date of prescription: _____ Discontinuation date: _____

For students with diabetes, the licensed prescriber should approve and sign the student's diabetes care plan

Self-administration of epinephrine: ❒ Yes ❒ No I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the above-mentioned medication and is capable of doing this independently. The student understands the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

_____ _____ _____

Licensed Prescriber Name (Print) *Signature of Licensed Prescriber* *Date*

Address: _____ *Telephone:* _____

B. TO BE COMPLETED BY THE PARENT/GUARDIAN FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION

Self-administration of asthma medication: ❒ Yes ❒ No I give permission for this child to carry the following medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

Diagnosis:_____ Name of medication:_____

Dosage:_____ Route of administration:_____

Time/Circumstances when medication should be administered: _____

Side effects:_____

Date of prescription: _____ Discontinuation date: _____

_____ _____

Parent/Guardian Signature *Date*

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STUDENT AGREEMENT

TO COMPLY WITH THE RULES FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION, EPINEPHRINE MEDICATION AND DIABETES MEDICATION AND EQUIPMENT

I,_____, am a student enrolled in Hawthorn School District 73. I further state that I have been prescribed medication to address my asthma/life threatening allergy/diabetes by a qualified health care professional. I hereby agree to comply with the following rules for self-administration of medication and use of medication equipment at school:

1. I will demonstrate proper use of the prescribed medication and equipment to the school nurse or other school employee designated to administer medication prior to possessing and self-administering the medication at school.

2. I will take care to keep my medication and equipment in my possession and under my control at all times.

3. I will never share my medication or equipment with another individual.

4. If I do not experience a marked improvement in my condition after two puffs of a prescribed inhaler, I will immediately see the nurse or other school employee designated to administer medication for further assessment of my condition; or

   After self-administering my epinephrine medication, I will immediately contact the nurse or other designated school employee so they may call 911 and monitor my condition; or

   If after treating my hypoglycemia or hyperglycemia I do not experience a marked improvement in my condition, I will immediately see the nurse or other school employee designated to administer medication for further assessment of my condition.

I understand that, if I am found abusing my medication or using it improperly, my parent/guardian will be notified and I may lose the ability to self-administer my medication at school.

Student Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____