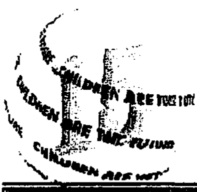

McHenry Elementary School District 15
1011 N. Green Street, McHenry, Illinois 60050
www.d15.org

REQUEST FOR THE ADMINISTRATION OF MEDICINE

Medications cannot be administered at school without a doctor's written order and a written request from the parent(s)/guardian(s). If possible, we request that medication be scheduled so as to not be given at school.

Student Name ______________________ Parent(s)/Guardian(s) Name ______________________

Address ______________________________________ Grade _____ School ___________

Home Phone _______________ Emergency Phone _______________

The following information is to be completed by the physician:

Medication Name __________________ Dosage ______________ Time to be given __________

Prescription Date _________ Discontinue Date ___________

Diagnosis for which the medication is prescribed ______________________

Is it necessary for this medication to be administered during the school day? yes ☐ no ☐

Side Effects: ____

Physician Printed Name ______________________________

Signature of Physician __________________________ Date ____________ Phone ________________

PARENT REQUEST FOR ADMINISTRATION OF MEDICINE AT SCHOOL

It is the belief of the Board of Education that medication should be administered at home. However, under certain conditions, it is in the best health and educational interest of the child to take prescribed medications during the school day. In such cases, the medication **must be prescribed by a doctor and a parental request must be on file in the Health Office.** To ensure compliance with the rules for administering medication at school, **medication must be brought to school by the parent or other responsible adult, in the original container properly labeled with directions and the doctor's name**. The student is responsible for coming to the Health Office to take the medicine. The parent of the student must assume responsibility for informing the school of any change in the child's health or change in medication. **Any change in medication or dosage will require a new request form to be submitted.** The School District retains the discretion to reject requests for the administration of medication. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a Registered Nurse and specifically consent to such practice. I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self administration of medication.

I request that the District Nurse or Building Principal make provision for my child _______________ to receive the medicine prescribed by Dr. __________________________ according to the instructions listed above. I also give permission for the District Nurse to contact the above physician in regard to any medication concerns.

_______________________________ ______________
Parent/Guardian Signature Date

Students Who Need to Carry Inhalers or an EpiPen® I authorize the School District and its agents to allow my child to possess and use his or her asthma medication and/or EpiPen®. I have instructed ___________ in the proper way to use his/her medication.

____________________ __________ ____________________ __________
Physician Signature Date Parent/Guardian Signature Date