# Newark Community High School
**District No. 18**
413 Chicago Road, Newark, IL 60541
Phone (815) 695-5164  Fax (815) 695-5752
Amy B. Smith, Superintendent
James Still, Principal


## Authorization and Permission for Administration of Medication
## (For Use of Prescription and Over-the-Counter Medication)

Students Name (Last), (First) (Middle) | Birth Date | Grade Level | Date

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

- *Physician/Prescriber signed dated authorization to administer the medication.*
- *The medication is in **the original labeled container** as dispensed or the manufacturer's labeled container.*
- *The medication label contains the student name, name of the medication, directions for use and date. Annual renewal of authorization and immediate notification, in writing, of changes.*

***Physician Authorization:***

_____ _____ _____
Medication / Treatment | Dose | Time to be administered

Please list other medication and additional information:

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## Physician Request for Self-Administration of Medication
## (For Inhalers and Epinephrine Auto-Injectors)

The above named student has _____
(an allergy or asthma)
Student must carry and self-administer the following medication, if needed, during school hours:
_____
(Name of Medication)
I certify that _____ has been instructed in the use and self-administration of this medication.
(Name of student)

**All medications given at school require the signature of the student's primary healthcare provider.**

_____ _____
***Prescriber's Signature*** | ***Date signed*** | ***Prescriber's Name (print)***

_____ _____
***Prescriber's Emergency Phone Number*** | ***Prescriber's Address***

Parental Authorization:
I herewith acknowledge 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 Newark Community High School and its employees and agent, on my behalf, to administer or to attempt 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 above. I acknowledge that it may 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 District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agent, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

***Parent's Signature*** | ***Date*** | ***Phone Number***