Addison Trail High School

213 N. Lombard Rd. Addison, Illinois 60101-1999
Nurse Office: (630) 628-3334
Nurse Fax: (630) 628-4189
Health Email: atphysicals@dupage88.net

Medication Authorization Form

This form must be submitted to the school health office. A physician's order is required for ANY medication, including over-the-counter. The school nurse **CANNOT** and **WILL NOT** administer medication without this form. Students are **NOT** permitted to have medication in their possession.

THE FOLLOWING MUST BE COMPLETED BY THE PARENT/GUARDIAN:

Student's Name _____ **Student ID#** _____
Address _____ **Phone Number** _____
Other medications the student is taking: _____

- ☐ I hereby request and grant permission to the authorized personnel from the above named school to administer the medication indicated on this form for my child.
- ☐ I give permission for my child to carry his/her inhaler and to be responsible in its use, provided the doctor gives consent for the same.
- ☐ I give permission for my child to self-administer his/her medication when on a field trip.

If there are any questions, please contact the school nurse at 630-628-3334.
All medication that is not self-carry needs to be picked up on the last day of school or it will be disposed of.

I indemnify and hold harmless DuPage High School District 88 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of medication or the medication storage by school personnel.

Parent/Guardian Signature _____ **Date** _____
Cell Phone _____ **Work Phone** _____ **Emergency Phone** _____

THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

Physician's Name (please print) _____ **Phone Number** _____
Physician's Address _____ **City** _____ **Zip Code** _____
Illness/Condition _____
MEDICATION _____ **Dosage** _____
Time to be administered _____ **Duration** _____
MEDICATION _____ **Dosage** _____
Time to be administered _____ **Duration** _____
Possible Side Effects: _____

- ☐ The above named student may self-administer his/her medication on a field trip. I certify that he/she has been properly instructed in its use.
- ☐ The above named student may carry and self-administer his/her inhaler. I certify that he/she has been properly instructed in its use.

Physician's Signature _____ **Date** _____

Important Information

1. Parent/Guardian MUST report any changes in prescription or dosage (a new form will need to be completed).
2. Medication authorization must be renewed at the beginning of each school year.
3. Medication (except inhaler if self-carry) will be kept in the Health Office.

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School Nurse
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Formulario de Autorización de Medicamento

Este formulario debe entregarse a la Oficina de Salud escolar. Se requiere la orden de un médico para CUALQUIER medicamento, incluso medicamentos sin receta. La enfermera de la escuela **NO PUEDE** y **NO ADMINISTRARÁ** medicamentos sin este formulario. **No** se les permite a los estudiantes tener medicamentos en su posesión.

LO SIGUIENTE DEBE SER COMPLETADO POR EL PADRE/TUTOR:

Nombre del Estudiante _____ **Número de ID#** _____
Domicilio _____ **Número de Teléfono** _____
Otros medicamentos que el estudiante está tomando: _____

- ☐ Yo solicito y otorgo permiso al personal autorizado de la escuela mencionada anteriormente que administre el medicamento indicado en este formulario a mi hijo(a).
- ☐ Yo doy permiso para que mi hijo(a) cargue su inhalador y sea responsable de su uso, siempre y cuando el médico dé su consentimiento para lo mismo.
- ☐ Yo doy permiso para que mi hijo(a) se autoadministre su medicamento cuando esté de paseo escolar.

Si tiene alguna pregunta, comuníquese con la enfermera de la escuela al 630-628-3334.
Todos los medicamentos deben recogerse el último día de clases o se desecharán.

Indemnizo y eximo de responsabilidad al Distrito 88 de Escuelas Secundarias de DuPage y sus empleados y agentes contra cualquier reclamo, excepto un reclamo basado en una conducta intencional, que surja de la autoadministración de medicamentos por parte del estudiante o del almacenamiento de medicamentos por parte del personal de la escuela.

Firma del Padre/Tutor _____ **Fecha** _____
Número de Celular _____ **Número de Trabajo** _____
Número de Emergencia _____

LO SIGUIENTE DEBE SER COMPLETADO POR EL MÉDICO:

Physician's Name (please print) _____ **Phone Number** _____
Physician's Address _____ **City** _____ **Zip Code** _____
Illness/Condition _____
MEDICATION _____ **Dosage** _____
Time to be administered _____ **Duration** _____
MEDICATION _____ **Dosage** _____
Time to be administered _____ **Duration** _____
Possible Side Effects: _____

- ☐ The above named student may self-administer his/her medication on a field trip. I certify that he/she has been properly instructed in its use.
- ☐ The above named student may carry and self-administer his/her inhaler. I certify that he/she has been properly instructed in its use.

Physician's Signature _____ **Date** _____

Información Importante

1. Los Padres/Tutores DEBEN informar sobre cualquier cambio en la receta o dosis (se necesitará completar un nuevo formulario).
2. La autorización de medicamento debe ser renovada al inicio de cada año escolar.
3. Los medicamentos (excepto el inhalador si el estudiante está autorizado para cargarlo) se guardarán en la oficina.

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