WOODLAWN
UNIT SCHOOL DISTRICT #209

Eric Helbig, Superintendent

Woodlawn High School
300 North Central Lane
Woodlawn, IL 62898
PH: 618.735.2631
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Eric Helbig
Principal

Woodlawn Grade School
301 South Central Lane
Woodlawn, IL 62898
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Sandra Kabat
Principal

PART 1:
MUST BE COMPLETED AND SIGNED BY THE CHILD'S PHYSICIAN OR PRESCRIBER:

CHILD'S NAME: ____

NAME OF MEDICATION: ____

DOSAGE: __________ FREQUENCY: __________ TIME TO BE GIVEN: __________

DATE OF PRESCRIPTION: ______________ DATE OF ORDER: ________________

DISCONTINUANCE DATE: ____

DIAGNOSIS REQUIRING MEDICATION: ______________________________

INTENDED EFFECT OF THIS MEDICATION: ___________________________

SIGNIFICANT SIDE EFFECTS IF ANY: ______________________________

TIME INTERVAL FOR RE-EVALUATION: ______________________________

OTHER MEDICATION CHILD IS RECEIVING: __________________________

THIS MEDICATION MUST BE ADMINISTERED DURING THE SCHOOL DAY (BETWEEN THE HOURS OF 8:00 AM AND 3:00 PM) IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL.

YES: ________ NO: ________

NONMEDICALLY TRAINED SCHOOL PERSONNEL MAY ADMINISTER THIS MEDICATION.

YES: ________ NO: ________

THE CHILD MAY SELF-MEDICATE HIM/HER SELF.

YES: ________ NO: ________

PHYSICIAN'S SIGNATURE (REQUIRED): ______________ DATE: _______

Medication must be brought to school by the parent in a container appropriately labeled by the pharmacy or the physician/prescriber. Medication orders should be renewed annually for long-term medications and any changes should be reported to the school nurse in writing.

PART 2: **MUST BE COMPLETED BY THE CHILD'S PARENT. PLEASE PRINT.**

CHILD'S NAME: ______________________________ BIRTH DATE: ________________

ADDRESS: ____________________________________ PHONE #: ________________

TEACHER: ________________________

PARENT/GUARDIAN EMERGENCY PHONE #: ________________________

PHYSICIAN/PRESCRIBER'S NAME: ______________________________

PHYSICIAN/PRESCRIBER'S ADDRESS: ____________________________

PHYSICIAN/PRESCRIBER'S OFFICE AND EMERGENCY #'S: ________________

I HEREBY CONFIRM 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 WOODLAWN UNIT SCHOOL DISTRICT 209 AND ITS EMPLOYEES AND AGENTS, IN 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 IN PART 1 OF THIS FORM.

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, 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 AGENTS, 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.

AS THE PARENT OR LEGAL GUARDIAN OF THE ABOVE NAMED CHILD, I HEREBY GRANT MY PERMISSION TO WOODLAWN UNIT SCHOOL DISTRICT 209 TO EXCHANGE INFORMATION CONCERNING THE CHILD'S MEDICAL CONDITION WITH THE NAMED PHYSICIAN FOR THE PURPOSE OF SAFE AND LEGAL ADMINISTRATION OF MEDICATION. IT IS UNDERSTOOD THAT THIS AUTHORIZATION MAY BE WITHDRAWN IN WRITING AT ANY TIME.

PARENT'S SIGNATURE (REQUIRED): ____________ DATE: __________

FOR OFFICE USE
PERSON(S) OBTAINING PERMISSION BY PHONE: ________________ DATE: __________

PERSON GRANTING PERMISSION BY PHONE: ________________ DATE: __________