Alton Community Unit School District #11
Alton, Illinois

Date____________________________

Dear Parent(s)

Alton Community Unit School District No 11 guidelines for the administration of medication include the following requirements:

1. No non-prescription medication will be administered at school.
2. **ONLY MEDICATION THAT IS ABSOLUTELY NECESSARY FOR THE CRITICAL HEALTH AND WELL BEING OF THE STUDENT WILL BE ADMINISTERED AT SCHOOL.**
3. The school nurse must receive a written statement form the student's physician stating that the medication is absolutely necessary for the critical health and well being of the student.
4. The student's physician must also provide the school nurse a written order detailing:
   a. the necessity for the medication during the day,
   b. the type of disease or illness involved,
   c. the benefits of the medication,
   d. the side effects,
   e. the name of the drug, dosage, and the time interval in which the medication is to be taken,
   f. and an emergency number where he/she can be reached.
5. **A NEW "MEDICATION AUTHORIZATION" FORM MUST BE SUBMITTED EACH SCHOOL YEAR. WE WILL NOT ACCEPT COPIES OF FORMS FROM PRIOR YEARS. ANY CHANGE IN MEDICATION OR DOSAGE WILL ALSO REQUIRE A NEW FORM.**
6. All approved medication must meet the above requirements. Such approved medication Must be brought in a container appropriately labeled by the physician or pharmacist. The parent or guardian must bring the medicine to school to avoid unsupervised transportation.
7. Parents are to use the School Medication Authorization Form (MN-24) for school administration of medication and the parent/guardian signature is required.
8. Students known to be allergic to "BEE" or other insect stings that may require emergency administration of medication and/or transportation to the hospital should have the Injectible Medication Authorization Form (MN-24c) completed and on file. You may get MN-24c from the school nurse or school principal.

Sincerely,

Student Health Services Director

Alton Community Unit School District #11
Medication Authorization Form
To be filed at the student's school building

Student's Name ______ **Birth Date** ______

Address ______

Home Phone ______ **Emergency Phone** ______

School ______ **Grade** ______ **Teacher** ______

To be completed by the student's physician

Name of Medication ______

Dosage ______ **Frequency** ______ **Time to be given in school** ______

Date of prescription ______ Date of Order ______ Discontinuation Date ______

Diagnosis requiring medication ______

Intended effect of this medication ______

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medication condition? ______

Expected side effects, if any ______

Time interval for reevaluation ______

☐ The medication above is to be self-administered, I certify that the student named above has been instructed in the use and self-administration of the above named medication and the child can fulfill the requirements of the procedure.

☐ The above student may carry the prescribed medication and /or inhaler.

Other medications student is receiving ______

Physician's Signature ______ **Date** ______

Physician's Name (please print) ______

Physician's Address ______

Office Phone ______ **Physician's Emergency phone** ______

I confirm that I am primarily responsible for the 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 Alton Community Unit School District #11 and its employees and agents, in my behalf and stead, 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. The School Nurse caring for my child may communicate with the prescribed physician regarding medications or health issues relating to this medication. 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 agents, either jointly or separately, 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) / Guardian(s) Signature ______

Parent(s) / Guardian(s) Name (Please Print) ______

Date ______