Dispensing Medicine Authorization Form

2018-2019 School Year

Student Name_____Grade_____Birth Date_____

Our school policy and guidance from the Illinois State Board of Education states that all prescription and non-prescription medications that are given during school hours or school-related activities must have this form completed PRIOR to the administration of any medication. Medication prescribed daily, twice, or three times daily should be administered outside of school hours. No medication will be given during the school day unless absolutely necessary for the critical health and well-being of the student.

All Medication sent to school must be:

1) In the original prescription container or original manufacturer's package if non-prescription medication;
2) Properly labeled with the name of the student; the prescribing physician, name of the medication, dosage, route, the time to be given, name of the pharmacy; and
3) Medication should be brought to school by the parent/guardian or other responsible adult.

A new **Dispensing Medicine Authorization Form** must be completed and signed by the parent/guardian and physician 1) at the beginning of each school year, 2) for each medication, 3) any time there is a change in the prescription of medication, and 4) overnight field trips requiring medication.

INFORMATION OBTAINED FROM PHYSICIAN:

Name of Medication and Dosage: _____

Route and Time: _____

Possible Side Effects: _____

Diagnosis/Reason for Medication: _____

Other Medications: _____

Prescriber Approval for Self-Carry and Administration _____ _____
(School policy only allows self-carry and administration for emergency medications) yes no

Is parent requesting for student to carry and use emergency medication? _____ _____
(Inhaler/epinephrine/diabetic drugs and supplies) yes no

_____ _____
(Physician's Signature) (Date)

_____ _____
(Physician's Name—Please Print) (Phone Number / Fax Number)

(Use for Physician's Address Stamp)

PARENT / GUARDIAN please review and complete side 2 →

TO BE COMPLETED BY PARENT/GUARDIAN, AS NEEDED

LIFE-THREATENING FOOD ALLERGY TREATMENT MEDICATION: If the above physician-prescribed medication is to treat an allergic reaction, parent/guardian must initial, agreeing to:

_____ Providing Trinity Oaks with the **Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form** that has been fully completed and signed by my student's physician, along with all prescribed rescue medications.

ASTHMA INHALER SELF CARRY AUTHORIZATION: TOCA will permit student to self-carry and self-administer asthma inhalers in a prescription labeled box during the school day, field trip or school sponsored event ONLY with parent/ guardian initials agreeing to ALL of the following:

_____ Providing Trinity Oaks with an **Asthma Action Plan** that has been fully complete and signed by my student's physician.

_____ I have provided TOCA with a copy of the prescription label on the asthma inhaler box.

_____ I agree to take full responsibility for the risks and consequences to my student if I do not provide the school office or field trip chaperone with an additional prescribed asthma inhaler.

_____ Providing Trinity Oaks with a **Self-Carry and Self-Administration of Medications Student Agreement**.

Administration of medication by Trinity Oaks Christian Academy personnel is contingent upon the following guidelines:

1. The PHYSICIAN'S ORDER must be fully complete, signed by the parent/guardian and physician, and turned into Trinity Oaks BEFORE any medication will be administered to the student.
2. The medication must be brought to the school office in a pharmaceutical container labeled with the student's name, name of medication, the dosage, and all pertinent instructions. Students permitted self-carry/self-administer asthma inhalers must carry prescription labeled inhaler.
3. Trinity Oaks does not have a nurse; therefore medication will be administered by non-medical school personnel.
4. The school will maintain a written record of any medication dispensed, including the student's name, name of medication, date/time it was administered, and by whom.
5. This form is valid for one school year only. Forms must be renewed each school year, with parent and physician signatures.
6. Any change in prescription of this medication requires a new **Dispensing Medicine Authorization Form**, complete with parent/guardian and physician signatures.
7. Overnight field trip medications require physician authorization, diagnosis, dosage and instructions to be provide to the school office 48 hours prior to departure. Students may self-carry/self-administer asthma inhaler if parent authorization, Student Agreement form, and prescription label is on file with the office.

PARENT/GUARDIAN SIGNATURE REQUIRED

PARENT/GUARDIAN AUTHORIZATION

I hereby confirm that I have reviewed and understand Trinity Oaks Christian Academy policy regarding the administration of prescription and OTC medications. On my behalf, I authorize Trinity Oaks Christian Academy and its employees to administer or attempt to administer to my child this lawfully prescribed medication in the manner described on the Physician's Order. I certify that I have legal authority to consent to medical treatment for the student named within this document, including the administration of medication at school. In addition, I agree to hold harmless and indemnify the school and its employees from and against any and all claims, damages, and causes of action or injuries incurred or resulting from the administration or attempt to administer said medication. I agree and specifically authorize school administration to provide health information about this student to school employees or approved parent chaperones, if in the school's discretion there is a need for them to know this information, to provide a safer environment for the student.

Parent/Guardian Signature _____ Date _____