**Evanston / Skokie**
**School District 65** **Health Services Department**

Dear Parent/Guardian:

If it is necessary for your child to take medication at school, you must read and complete the following form.

Medicine can only be given by school personnel if ordered by a physician. Medication ordered by a physician or labeled by a pharmacist needs only a parent request (part 1). Request to give over the counter medication or to have a child carry their medications must be accompanied by a signed request from both the physician and the parent/guardian (parts 1 and 2).

**PARENTAL MEDICATION REQUEST**

I HEARBY CONFIRM MY PRIMARY RESPONSIBILITY TO ADMINISTER MEDICATION TO MY CHILD. HOWEVER, IF MY CHILD MUST RECEIVE MEDICATION WHILE IN SCHOOL, I AUTHORIZE SCHOOL DISTRICT 65 AND ITS EMPLOYEES TO ADMINISTER LAWFULLY PRESCRIBED MEDICATION TO MY CHILD. I ACKNOWLEDGE THAT IT MAY BE NECESSARY THAT THE ADMINISTRATION OF MEDICATIONS TO MY CHILD BE PERFORMED BY A HEALTH CLERK OR OTHER INDIVIDUAL WHO IS NOT A CERTIFIED 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 AND ITS EMPLOYEES AND AGENTS ARISING OUT OF THE ADMINISTRATION OF SAID MEDICATION. IN ADDITION, I AGREE TO HOLD HARMLESS AND INDEMNIFY THE SCHOOL DISTRICT AND ITS EMPLOYEES 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.

I WILL NOTIFY THE SCHOOL OF ANY CHANGE IN MEDICATION OR DOSAGE AND WILL SEND THE SCHOOL A WRITTEN ORDER FROM THE DOCTOR WHEN A CHANGE IS NECESSARY.

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**PART 1**

**I HEREBY REQUEST THAT SCHOOL PERSONNEL ADMINISTER THE FOLLOWING MEDICATION(S) TO:**

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**NAME OF CHILD**

1. Medications and treatments as prescribed by medical
**MEDICATION** **DOSAGE** **TIME** **START & STOP DATES**

2. provider with notification from parent (see prescription)
**MEDICATION** **DOSAGE** **TIME** **START & STOP DATES**

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**PARENT'S/GUARDIAN'S SIGNATURE** **DATE**

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**PART 2**

Physician's signature required for over the counter medications, child to carry medications, additional clarification, etc.
Requests/comments:

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**PHYSICIAN'S SIGNATURE** **DATE** **TELEPHONE NUMBER**

M-145
(Rev. 2/04)