COMMUNITY UNIT SCHOOL DISTRICT #4

STUDENT WELFARE (ADMINISTERING MEDICATION TO STUDENTS)

Medication required by a student shall generally not be administered at school by a district employee. This policy includes both common and widely used over-the-counter medications such as Tylenol, cough syrup, Advil, etc. as well as prescription drugs.

However, students recovering from temporary illness or students on permanent medication who require medication during the school day may have medication at school following these guidelines.

1. The parent/guardian shall personally deliver the medication to be administered to the building principal.
2. A medication authorization form signed by a doctor and parent will be delivered to school with the medication.
3. Medication shall be brought to school in the original, secured and properly labeled containers. The name of student, physician, and pharmacy with phone numbers will be on the container.
4. Medication shall be administered by an Administrator or their Designee.

Should a student require a continuing program of medication, and it can be demonstrated that the student is of responsible age, arrangements may be made for self-administration of the medicine. This procedure shall be allowed after the following conditions have been met:

- A written release of liability from the parent/guardian (**forms available at all Principal's Offices**).
- Written permission from an administrator.
- Medication authorization form **signed by parent and doctor.**

All medicines will be stored in locked cabinets – all controlled drugs will be double locked. In all cases, the school retains the discretion to reject a request for administering medicine. Except as permitted, in accordance with this policy, no medication shall be used or possessed by students on school grounds.

Authorization for the Administration of Medication C.U.S.D. #4, Mendon, Illinois
Student Name:_____ Date of Birth:_____ Address:_____ City:_____ Phone:_____ School:_____ Teacher and Grade:_____
PHYSICIAN'S STATEMENT (to be completed by Doctor)
1. Name/Type of Medication:
2. Dosage/Amount to be Given:
3. Frequency/Times to be Administered:
Student Self Administration: (Circle One) YES NO
4. Durations (Weeks, Month, Indefinite, Etc.):
5. Anticipated Reaction to Medication: (Symptoms, side effects, etc.)
6. Diagnosis:
7. Other Medication Student is Taking:
PHYSICIAN'S SIGNATURE: DATE:
PHYSICIAN'S ADDRESS:
PHYSICIAN'S PHONE:
PARENT'S REQUEST/APPROVAL: I hereby request and give my permission for the above named school to administer the medication prescribed on this form to my child, and thereby release the school from any liability.
PARENT'S SIGNATURE: DATE: