Peru Elementary School District 124

Northview Elementary School
2100 Plum Street
Peru, Illinois 61354

School District Office
1800 Church Street
Peru, Illinois 61354

Parkside Middle School
1800 Church Street
Peru, Illinois 61354

815-223-1111 **www.perued.net**

SCHOOL MEDICATION AUTHORIZATION FORM

I understand that Peru Elementary School District 124 discourages administration of medication in school. I herewith acknowledge that I am primarily responsible for administering medication to my child. In the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Peru Elementary School District 124 and its employees and agents, on my behalf and instead, to administer or attempt to administer to my child, or to allow my child to self-administer while under the supervision of the employees and agents of District 124, lawfully prescribed medication in the manner described below. I hereby release the School Board of District 124 and their agents and employees from any and all liability that may result from the administration of the below medication. I agree to bring the medication to the school nurse in the properly labeled container from the pharmacy.

Student's Name: _____

Date of Birth: _____ Grade: _____

Name of Medication: _____

Medication: ☐ Tablet/Capsule ☐ Ointment ☐ Liquid ☐ Inhalation ☐ Injection

If other, please specify:_____

Dosage to be given: _____

Time of Medication Administration: _____ ☐ AM ☐ PM

Side Effects (expected or predictable): _____

_____

Recommended action if side effects occur: _____

_____

Contraindications for the administration of this Medication: _____

_____

Reason for the administration of the Medication (Student's Diagnosis):

_____

Does this student have permission to self-medicate? ☐ Yes ☐ No

If yes, please make sure that your child is capable of using this medication independently, understands the need for the medication, is instructed in the side effects of the medication and the necessity to report the side effects to school personnel.

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Phone: _____