

Student I.D. # \_\_\_\_\_  
 Numero de Identificación del Estudiante

Date Received: \_\_\_\_\_  
 Recibido el Día

Nurse Reviewed: \_\_\_\_\_  
 Revisado por Enfermera

## Permission Form to Administer Medications

Forma de Permiso para Administrar Medicamentos

### Township High School District 113

**Deerfield High School**  
 1959 N. Waukegan Rd. Deerfield, IL 60015  
 Phone: 224/632/3200; Fax: 224/632/3206  
 Teléfono Fax

**Highland Park High School**  
 433 Vine Ave. Highland Park, IL 60035  
 Phone: 224/765/2200; Fax: 224/765/2708  
 Teléfono Fax

### All Medication Must Be Properly Labeled

Todo medicamento debe estar etiquetado adecuadamente

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Fr. So. Jr. Sr.  
 Nombre del Estudiante Last First Fecha de Nacimiento 9 10 11 12 (grado)  
Apellido Primer Nombre

Start Date \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_  
 Fecha de Comienzo Fecha de Descontinuación

Diagnosis/Reason \_\_\_\_\_  
 Diagnóstico/Razón

Medication: \_\_\_\_\_  
 Medicamento

Daily: \_\_\_\_\_ PRN: \_\_\_\_\_ Emergency: \_\_\_\_\_  
Diario Cuando sea necesario Emergencia

1. Strength: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Time: \_\_\_\_\_  
Potencia Dosis Frecuencia Hora

2. Route of administering: \_\_\_\_\_  
Forma de administrar

3. Side effects student should be observed for: \_\_\_\_\_  
Efectos secundarios por los cuales el estudiante debe tenerse en observación

4. Other medication student is receiving: \_\_\_\_\_  
Otros medicamentos que el estudiante recibe

I hereby request and grant permission for Township High School District 113 school nurse or any registered nurse approved by the District, or in the case of an emergency, another staff member, administer medication to my student according to the above instructions. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the storage, administration, or self-administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication, except for willful and wanton conduct. (este párrafo esta en español en la parte posterior)

**For Asthma Medication/Epinephrine Auto-Injectors/Diabetes Medication\* Only:** I consent to my student's possession and unsupervised self-administration of (circle applicable medication) asthma medication/epinephrine auto-injectors/diabetes medication: \_\_\_\_\_yes \_\_\_\_\_ no. (este párrafo esta en español en la parte posterior)

\* A student must be authorized to self-administer insulin in accordance with the student's individual health care plan, Section 504 plan, or diabetes care plan. (este párrafo está en español en la parte posterior)

\_\_\_\_\_  
 Parent/ Guardian signature  
Firma del Padre/Tutor

\_\_\_\_\_  
 Licensed Prescriber signature  
Firma del Prescriptor con Licencia

\_\_\_\_\_  
 Emergency # of Parent/Guardian  
No. de Emergencia del Padre/Tutor

\_\_\_\_\_  
 Address/Phone  
Dirección/Teléfono

\_\_\_\_\_  
 Date  
Fecha

\_\_\_\_\_  
 Date  
Fecha

**Medication cannot be given unless this form is completed in its entirety and signed by the licensed prescriber and parent/guardian\***

El medicamento no puede ser dado a menos que esta forma sea llenada en su totalidad y firmada por el prescriptor con licencia y el padre/tutor

\*The licensed prescriber signature is not required for a student's self-administration of asthma inhalers.

\*La firma del prescriptor con licencia no es requerida para la auto-administración de inhaladores de asma de un estudiante.