EST. 1999
PRAIRIE CROSSING
CHARTER SCHOOL
CREATING NATURAL LEADERS

_____/__/_____ _____

Student Name DOB Date

____ My child will not need any prescription or over the counter medications during the school day. (Please proceed to *Allergy History Form*.)

2016 – 2017 School Medication Authorization Form

(For all prescription or non-prescription medications except for epinephrine injector or asthma inhaler)

Prairie Crossing Charter School policy states that, except for the limited exceptions recognized in the policy, no student shall possess or consume, and no Prairie Crossing Charter School employee shall administer to any student, or supervise any student's self-administration of, any prescription or nonprescription medication on school grounds or at a school-related function unless and until the student's parent/guardian has completed and signed this "School Medication Authorization Form" and returned that form and a prescription for the medication from a licensed medical provider to the Building Principal or his or her designee. All medication must be in the original labeled container as dispensed or manufacturer's labeled container and the label must contain the student name, name of the medication, directions for use, and date. Notwithstanding the foregoing, no school employee is prohibited from providing emergency assistance to a student, including administering medication to a student in an emergency situation.

This form must be completed annually by both a licensed prescriber and the parent/guardian of the student. The parent/guardian must notify Prairie Crossing Charter School immediately of any changes required for the administration of medication by delivering a new form completed by the parent/guardian and the licensed prescriber indicating the changes. Please see Prairie Crossing Charter School's medication policy for a full description of medication guidelines.

ALL MEDICATIONS MUST BE TURNED INTO THE OFFICE. NO MEDICATIONS ARE TO BE TURNED INTO A TEACHER.

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_____/__/_____
Student Name DOB

To be completed by licensed prescriber (one medication per form):

_____/___/_____
Student's Name (Last) (First) (Middle initial) Birth date Grade

_____
Diagnosis requiring medication Reason for medication during school hours

_____
Name of medication Dosage

_____
Administration route or other directions

_____
Frequency Time to be given Intended effect of medication

Anticipated side effects: ( ) None anticipated. ( ) Yes. **If yes, please describe:** _____

_____

_____
Other medication(s) the student is receiving.

_____
Start date of administration Discontinue/reevaluate/follow-up date (circle one)

Grayslake, IL 60030-3536
Visit us at prairiecrossingcharterschool.org
847-543-9722 Phone
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Revised 4/2016
LW, RN