BIG HOLLOW SCHOOL DISTRICT
www.bighollow.us

Big Hollow District Office
26051 W. Nippersink Rd.
Ingleside, IL 60041
Phone (847) 740-1490
FAX (847) 740-9172

Big Hollow Primary School (EC-1)
33335 N. Fish Lake Rd
Ingleside, IL 60041
847-740-5320
Fax 847-740-3490

Big Hollow Elementary (2-4)
33315 N. Fish Lake Rd
Ingleside, IL 60041
847-740-5321
Fax 847-740-3795

Big Hollow Middle School (5-8)
26051 W. Nippersink
Ingleside, IL 60041
847-740-5322
Fax 847-740-9021

MEDICATION ADMINISTRATION CONSENT FORM

Student Name: _____ DOB: _____ School Year: _____

Only medications that are absolutely necessary for the student to take in order to complete the school day will be administered during school hours. District policy states that prescription and over-the-counter medications may be administered only upon written request of bot the student's physician and parent/guardian. All medications must be brought to and from the school by the parent/guardian in the original container labeled with the student's name, date of birth, and dosage instructions. This form must be completed and returned to the nurse's office before medication can be taken. This is the only acceptable form. The school must be notified in writing of any changes. The school district retains the discretion to reject requests for self-administration of medications.

My child requires medication that must be taken during school hours. I authorize the school to supervise the administration of this medication in accordance with the physician's directions. I understand that my signature on this form constitutes a waiver by me to the staff, school district, its board and members, and other school personnel for the liability for unexpected reactions when the medication is administered as ordered.

I have read and consent to the school medication administration policy.

_____ _____ _____
Signature of Parent/Guardian | Date | Emergency Phone Number

_____

****Only ONE medication per Form****

PHYSICIAN'S ORDER AND AUTHORIZATION/CAREPLAN

Student's Name: _____
Name of Medication: _____ Dose: _____
Route: _____ Frequency: _____ Length of Time Required: _____
Diagnosis for which the Medication is Prescribed: _____
Expected therapeutic effects of medication: _____
Possible Side Effects: _____

Please check the following box **ONLY** for students with inhalers, epinephrine pens, or insulin

All other medication must be stored in the nurse's office.

☐ I certify that the above named student has been instructed in the use and self-administration of this medication. He/She understands the need for the administration of this medication. He/She understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication properly and possessing it at school. I may be reached at the following phone number in the event of an emergency.

Note: If any medications, testing supplies, etc. are found not disposed of properly, students may lose the privilege of carrying the medication themselves.

_____ _____
Print Name of Physician | Telephone Number

_____ _____
Signature of Physician | Date