LINCOLN-WAY
Community High School
District 210

District Administration

Dr. Lawrence A. Wyllie
Superintendent
815.462.2130

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Deputy Superintendent
815.462.2125

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Assistant Superintendent
815.462.2122

Mr. Ronald R. Sawin
Assistant Superintendent
815.462.2111

Administrative Offices

1801 E. Lincoln Hwy.
New Lenox, IL 60451-2098
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RECOMMENDED GUIDELINES FOR MEDICATION ADMINISTRATION IN SCHOOL

The purpose of administering medications in school is to help each child maintain an optimal state of health that may enhance his/her education plan. The medications shall be those required during school hours that are necessary to provide the student access to the educational program.

The intent of these guidelines is to reduce the number of medications given in school, yet assure safe administration of medications for those children who require them.

GUIDELINES:

1. All medication, including non-prescription drugs, given in school shall be prescribed by a doctor. A written order from the prescribing doctor must be provided with the name of the medication, dosage, and time intervals that the medication is to be taken.

2. Medication must be brought to school in the original package or appropriately-labeled container. Over the counter medication shall be brought in with the manufacturer's original label and the student's name affixed to the container.

3. Written parental/guardian consent is to be placed on file requesting that the medication be given during school hours.

4. The administration of medication to students in school is managed by the school nurse. All questions regarding this policy can be made by contacting the nurse at the appropriate campus.

Central Campus	815-462-2260
East Campus	815-464-4144
North Campus	815-534-3045
West Campus	815-717-3545

LINCOLN-WAY HIGH SCHOOL DISTRICT 210 – MEDICATION AUTHORIZATION FORM

Please return this form to the school nurse

STUDENT NAME: _____

STUDENT ID# _____ GRADE _____ DATE OF BIRTH _____

Physician's orders: (To be filled out by the attending Doctor – please print)

Medication #1. _____ Dosage _____ Route _____

Time to be given _____ Reason for prescribing medication _____

Possible side effects of medication _____

Medication #2. _____ Dosage _____ Route _____

Time to be given _____ Reason for prescribing medication _____

Possible side effects of medication _____

Medication #3. _____ Dosage _____ Route _____

Time to be given _____ Reason for prescribing medication _____

Possible side effects of medication _____

Medication #4. _____ Dosage _____ Route _____

Time to be given _____ Reason for prescribing medication _____

Possible side effects of medication _____

Physician's signature _____ Date _____

Address _____ Phone Number _____

Parent Authorization: (To be completed by parent/guardian)

I hereby grant my permission for Lincoln-Way High school to administer to _____ the above named medication as prescribed by the above physician. I agree to provide medication in a properly labeled bottle from the pharmacy. The medication will be kept in the nurse's office, and the student will report to the nurse's office to receive the prescribed medication.

Please check this box if this medication was prescribed for Band camp or a Lincoln-Way District 210 outside activity ☐

Parent/Guardian Signature: _____

Address _____

Home Phone No. _____ Work Phone No. _____ Date _____

Nurse: **(To be completed by school nurse)**

Medication #1. _____ Dosage _____ Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Medication #2. _____ Dosage _____ Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Medication #3. _____ Dosage _____ Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Medication #4. _____ Dosage _____ Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Special instruction for dispensing #1 _____ #2 _____

#3 _____ #4 _____

Other Medication needed _____

School Nurse Signature _____ Date _____