

North Shore Academy – Elementary
255 Revere Dr. Suite 100
Northbrook, IL 60062
(847) 291-7905 Fax (847) 291-9641

MEDICATION POLICY

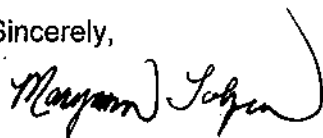
In accordance with the State of Illinois, the North Shore Academy Medication Policy is as follows:

- A physician's written order is needed for your student to receive any prescription and/or over-the-counter medications (such as Tylenol and Advil) while at school.
- The permission form must be renewed each year. Attached are the forms to be used for prescription medication and for over-the-counter medications.
- The medication must be brought to school by the parent or guardian of the student. Students are not allowed to transport medications to or from school.
- Medications must be brought to school in the original pharmacy container with label, or in the original container for over-the-counter products.

Please contact me if you have any questions.

Your cooperation is greatly appreciated.

Sincerely,



Maryann Tolzien
NSSED Program Nurse
Cell (847) 702-7022

NORTHERN SUBURBAN SPECIAL EDUCATION DISTRICT

760 Red Oak Lane Highland Park, IL 60035

847-831-3100 Fax: 847-831-5108

This order will be effective for
2011-2012 + extended school year
or until further notice

Student's Name: _____ Birth Date ____/____/____

School North Shore Academy School Year (including ESY) 2011 / - / 2012

**WRITTEN ORDER AND PERMIT TO ADMINISTER PRESCRIPTION, OTC NON-PRESCRIPTION
MEDICATION, VITAMINS AND HERBALS DURING SCHOOL HOURS**

Name of Medication _____ Dosage _____

Route of Administration _____

Frequency and Time of Administration _____

Diagnosis Requiring Medication _____

Intended Effects of Medication _____

Side Effects of Medication _____

Other Medications Student is Receiving _____

Printed Name of Physician _____ Date ____/____/____

Signature of Physician _____

Address _____

Phone _____ FAX _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and grant permission for Northern Suburban Special Education District to administer, or supervise the self-administration of medication to my son/daughter, _____ according to the above instructions. I further waive any claims against the District, members of its Board, its employees, and agents, either jointly or severally, from and against any and all liability, claims, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration of said medication.

I, _____, give permission for my child to receive the above medication(s) as directed by the physician. I will provide all supplies needed to do the procedure. I will notify the school in writing if the medication is discontinued.

Parent's Signature: _____ Date ____/____/____

Address _____

Home Phone _____ Cell _____ Work _____

MEDICATION INFORMATION

Student's Name _____

Birthdate ____/____/____

For student currently NOT receiving medication check here: _____

For student receiving medication at home:

It is important that our records indicate medications taken at home. This information is necessary in care of **EMERGENCY** treatment or the influence it will have on the student's performance in school. Please **NOTIFY** the nurse if there are **ANY CHANGES IN MEDICATION** during the school year.

NAME OF MEDICATION

DOSAGE AND TIME

It is important that our records indicate medications taken at home. This information is necessary in case of **EMERGENCY** treatment or the influence it will have on the student's performance in school. Please **NOTIFY** the nurse if there are **ANY CHANGES IN MEDICATION** during the school year.

NAME OF MEDICATION

DOSAGE AND TIME

DATE: _____ PARENT'S SIGNATURE _____

FOR STUDENTS RECEIVING MEDICATION DURING SCHOOL HOURS

1. Only those medications necessary to maintain a student in school and which must be given during school hours may be administered to a student. Please have your physician complete the form on the reverse side.
2. In addition to the licensed prescriber, the parent/legal guardian portion must be signed.
3. Medication must be brought to school in the original package or a container with a pharmacy label.
 - A. Prescription medications shall display:
 - Child's Name
 - Prescription Number
 - Medication Name/Dosage
 - Administration Route and/or Other Directions
 - Date and Refill
 - Licensed Prescriber's Name
 - Pharmacy Name, Address and Phone Number
 - Name or Initials of Pharmacist
 - B. Over the Counter Medications (OTC):
OTC non-prescription medications shall be brought in with the manufacturer's original label with the ingredients listed and the child's name affixed to the container.

NORTHERN SUBURBAN SPECIAL EDUCATION DISTRICT
760 Red Oak Lane Highland Park, IL 60035
847-831-3100 Fax: 847-831-5108
MEDICATION ADMINISTRATION AUTHORIZATION FORM
PRN REQUEST FOR DISCOMFORT/HEADACHE

Student's Name: _____ Birth Date ____/____/____

School NORTH SHORE ACADEMY School Year 2011-2012

WRITTEN ORDER AND PERMIT TO ADMINISTER PRESCRIPTION, OTC NON-PRESCRIPTION
MEDICATION, VITAMINS AND HERBALS DURING SCHOOL HOURS

Name of Medication IBUPROGEN 400 MG OR ACETAMINOPHEN 500-1000

Dosage ii x 200 MG TABS i-ii x 500 MG TABS

Route of Administration ORAL

Frequency and Time of Administration EVERY 6 HOURS AS NEEDED

Diagnosis Requiring Medication DISCOMFORT/HEADACHE

Intended Effects of Medication RELIEF OF DISCOMFORT OR HEADACHE

Side Effects of Medication NAUSEA

Other Medications Student Is Receiving _____

Printed Name of Physician _____ Date ____/____/____

Signature of Physician _____

Address _____

Phone _____ FAX _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and grant permission for Northern Suburban Special Education District to administer, or supervise the self-administration of medication to my son/daughter, _____ according to the above instructions. I further waive any claims against the District, members of its Board, its employees, and agents, either jointly or severally, from and against any and all liability, claims, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration of said medication.

I, _____, give permission for my child to receive the above medication(s) as directed by the physician. I will provide all supplies needed to do the procedure. I will notify the school in writing if the medication is discontinued.

Parent's Signature: _____ Date ____/____/____

Address _____

Home Phone _____ Cell _____ Work _____