IMSA
Illinois Mathematics and Science Academy

Authorization for Administration of Prescription Medications

Phone: (630)907-5008
Fax: (630)907-5938
Nurse@imsa.edu

Illinois Mathematics and Science Academy

Student Name (print) _____ Birth Date _____

Year of Graduation _____ Residence Hall _____

To be completed by the student's physician:

Name of Medication (print)	Strength	Dosage	Frequency	Time

Diagnosis: _____

Over-the counter medications, vitamins, and/or herbal supplements that are contraindicated:

_____

Additional instructions:_____

Physician Name (print or stamp): _____

Address:_____ Phone:_____

City, State, Zip: _____ Fax:_____

Physician's Signature:_____ Date:_____

Helpful Hints

1. Please give new medication or refills to the Health Office, Monday through Friday, 7:30 am to 4 pm, or a Resident Counselor (RC), and they will turn it in to the Health Office by 9:00 am the next day.
2. When a prescription is refilled, please reserve a sufficient quantity at home to cover the expected time at home before the next refill. It would be advisable to obtain an extra bottle from the pharmacy when the prescription is obtained to keep at home with the remainder of the medication.
3. It would be helpful if you obtained 3 additional labeled bottles from the pharmacy when the prescription is filled for use at IMSA on the weekends (they will do this at no charge). *This would only apply at the beginning of the year or with any prescription dosage change.*

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4. If your student is going home and you need a supply of medication:
   a. Contact the Health Office 48 hours prior to leaving campus at 630-907-5008 or nurse@imsa.edu
   b. Parent/Guardian can pick up the medication from the health office before 3:00 pm
   c. Parent/Guardian can pick up the medication from the RC Office of your student's Residence hall after 3:30 pm.

The parent/guardian will be responsible at the end of the treatment period, or at the end of the year, to pick up the student's medication, or it will be sent to Walgreens for disposal or destruction ten days after graduation.

To be completed by parent:

I hereby authorize Illinois Mathematics & Science Academy and its employees and agents, on my behalf and in my stead, to administer or attempt to administer to my child (or to allow my child to self-administer while under the supervision of the employees and agents of the Academy), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and expressly consent to such practice.

I further acknowledge and agree that when the lawfully prescribed medication is administered or attempted to be administered, I waive any claims I might have against the Academy and its employees and agents arising from administering said medication. In addition, I agree to hold harmless and indemnify the Academy, its employees, and agents, either jointly or severally, from and against any and all claims, damages, causes of action, or injuries incurred or resulting from the administration or attempts at administering said medication.

I have read and understand this agreement. My questions have been answered to my satisfaction by IMSA Student Health Care Services Office personnel. I agree to abide by IMSA's policies regarding administering prescription medication to my child.

Parent/ Guardian Signature _____ Date _____

Printed Name _____

To be completed by student:

I understand that IMSA supports my physician's treatment goals for me: improving health, enhancing well-being, and promoting optimal functioning. I agree to obtain medication from the IMSA Student Health Care Services Office and take it as prescribed by my physician until I am released from treatment by my physician. I agree to communicate written orders from my physician to the health office staff regarding any change in medication, dosage, and timing. I acknowledge that failure to follow my physician's treatment recommendations may jeopardize my health and continued enrollment at the Academy.

I have read and understand this agreement. IMSA Student Health Care Services Office personnel have answered my questions to my satisfaction. I agree to be responsible for taking care of myself appropriately.

Student Signature _____ Date _____

Print Name _____