STAUNTON COMMUNITY UNIT SCHOOL DISTRICT NO. 6

801 North Deneen St. · Staunton, IL 62088
(618) 635-2962 · Fax (618) 635-2994 · www.stauntonschools.org

Staunton Community Unit School District #6 Expects Everyone's Best
**LEAD *CHALLENGE *ACHIEVE*

REQUEST FOR THE ADMINISTRATION OF MEDICINE

STUDENT'S NAME: _____ Date of Birth: _____ Grade/Teacher: _____

PART I – LICENSED PRESCRIBER'S AUTHORIZATION

1. Name / type of medication: _____
2. Dosage / amount to be given: _____
3. Route of administration: _____
4. Frequency and time of administration: _____
5. Duration (week, month, indefinite, etc.): _____
6. Diagnosis a) _____
   b) _____
7. Intended effect, and anticipated reaction to medication:
   a) _____
   b) _____

_____ _____
Licensed Prescriber's Signature (required) Date Signed

_____
(Print) Licensed Prescriber's Name

PART II – PARENT'S REQUEST / APPROVAL

I, _____, hereby request and grant permission for Staunton CUSD#6 school nurse or trained personnel to administer above stated medication to my child. (Medication will be stored in a locked medication cabinet.)

I understand that an individual other than a school nurse may perform this administration, and I specifically consent to this. I further waive any claims against Staunton CUSD#6, members of the Board of Education, its employees, and / or agents arising out of the administration of said medication and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees, and / or agents, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney fees, resulting from or arising out of the administration, or self-administration of medication to my child.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

Parent/Guardian (s) Signature _____ Phone # _____ Date _____

School Nurse Signature _____ Date Received _____

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