

Jersey Community Unit School District No. 100

100 Lincoln Ave. - Jerseyville, IL 62052
Phone: 618-498-5561 Fax: 618-498-5265

**ORDER FOR PRESCRIPTION AND NONPRESCRIPTION MEDICATIONS
TO BE GIVEN TO STUDENT'S DURING SCHOOL HOURS**

Student's Name: _____ Date of Birth: _____

School: _____ Phone: _____

Grade: _____ Teacher: _____

I hereby authorize Jersey Community Unit School District No. 100 and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described below. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District and its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District and 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 of said medication.

Parent Signature

Date

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

Licensed Prescriber's Signature: _____

Prescriber's Phone Number: _____

Prescriber's Address: _____

Name of Medication: _____

Dosage: _____ Route of Administration: _____

Frequency and Time of Administration During School Hours: _____

Date of Prescription: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis Requiring Medication: _____

Intended Effect of the Medication: _____

Side Effects: _____

Other Medications the Child is Receiving: _____

Time Interval for Reevaluation _____