Elementary School District 102
MEDICATION AUTHORIZATION FORM

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TO BE COMPLETED BY PARENT/GUARDIAN:

Name of Student: ________________________________ Date of Birth: ____________

School: ____ Grade:__________________

Address: ____

Parents' Names: ____

Home Telephone: ____

Emergency Telephone:____

TO BE COMPLETED BY the student's physician; physician assistant; or advanced practice registered nurse:

Name of Medication	Dosage	Frequency	Time to be Given at School	Duration	Side Effects (if any)

Special Instructions: ____
____
____

Signature of Licensed Prescriber: _____________________________ Date:_________

Printed Name: ____

Address:_______________________________________ Telephone:________________

Elementary School District 102
MEDICATION AUTHORIZATION FORM

Name of Student: ________________________________ Date of Birth: ____________

TO BE COMPLETED BY PARENT/GUARDIAN:

I hereby authorize District 102 personnel to administer the above referenced medication to my son/daughter, ______________________________________, at school and during school-related activities.

I hereby agree that the School District shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of medication. I agree to indemnify and hold harmless the School District, its Board of Education and the individual Board members, officers, employees and volunteers from any claim, liability, loss or expense, including reasonable attorney's fees, arising out of a claim related directly or indirectly to the administration of the above referenced medication brought by me, any other parent/guardian of my child, or by or on behalf of my child or any other student, except for claims resulting from willful and wanton conduct.

____ ___________________________

Signature of Parent/Guardian Date

This form shall be effective for one year.