Franklin Community Unit School District #1

STUDENT MEDICATION/TREATMENT AUTHORIZATION FORM

Name of Student _____ Birthdate _____

Home Phone _____ Emergency Phone _____

School _____ Grade _____ Teacher _____

To be completed by the student's physician:

Physician's Printed Name: _____

Office Phone: _____

Medication name: _____

Dosage: _____ Route: _____

Time medication is to be administered at school: _____

Prescription date: _____ Discontinuation date: _____

Diagnosis: _____

Expected side effects, if any: _____

Physician's signature _____ Date _____

For all parent(s)/guardian(s)

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner prescribed 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 specifically consent to such practices,** and I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian Printed Name _____

Phone _____ Emergency Phone _____

Parent/Guardian Signature _____ Date _____