COMMUNITY UNIT SCHOOL DISTRICT #7

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME: _____ BIRTHDATE: _____

ADDRESS: _____ HOME PHONE: _____

TEACHER: _____ GRADE: _____ EMERGENCY PHONE: _____

By signing below, I agree:

1. 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 and stead, to administer or to attempt to administer to my child, or to allow my child to self-administer, lawfully prescribed medication in the manner described by our physician.
2. That when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. To indemnify and hold harmless 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration, attempts at administration, or self administration of said medication.
3. That the school may contact the physician if there are problems regarding this medication, which includes psychiatric medications prescribed to be taken during the school hours.
4. 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.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

MEDICATION: _____ DOSAGE: _____

TIME AND FREQUENCY TO BE GIVEN: _____

DIAGNOSIS: _____ EFFECTIVE FROM: _____ TO: _____

POSSIBLE SIDE EFFECTS: _____

MUST THIS MEDICATION BE GIVEN DURING THE SCHOOL DAY? _____ YES _____ NO

_____

PHYSICIAN'S PRINTED NAME **ADDRESS** **PHONE #**

_____

PHYSICIAN'S SIGNATURE **DATE** **FAX #**