HERRIN COMMUNITY UNIT DISTRICT NO. 4
STARS AFTER-SCHOOL PROGRAM

SCHOOL MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN:

Student's Name____ **Birthdate**___________

Address____

Phone_______________________ **Grade**________________ **Emergency Phone**____________

Teacher____________________________

I hereby authorize Herrin CUSD No. 4 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, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school district, 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. I authorize communication between the school nurse, building principal/designee and the physician noted below in the care of my child in the school setting.

Signature of Parent/Guardian_______________________________________Date____________________

MUST BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Name of Medication____

Dosage___________________________________ Time ____________________________________

Duration of Administration____

Type of Disease or Illness____

Must this medication be administered during the school day in order to allow the child to attend school or to address the child's medical condition? ________________

Side Effects to Be Alert To____

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Doctor's Name (Please Print or Type)_________________________________Phone_______________________

Doctor's Signature____Date_______________________

Doctor's Address____

Emergency Number____

Further Instructions or Comments: