

School Medication Authorization Form - School District 20

Student's Name _____

Birth Date _____

Address _____

Home Phone _____

School _____ Grade _____

Teacher _____

Emergency Phone No: _____

To be completed by the student's physician:

Name of Medication:

Dosage _____ Frequency _____

Time to be given in school _____

Date of prescription _____

Date of order _____

Discontinuation date _____

Diagnosis requiring medication _____

Intended effect of this medication

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

Expected side effects, if any:

Time interval for re-evaluation:

Other medications student is receiving:

Physician's name - signature _____

Physician's name - print _____

Address:

Office Phone: _____

Emergency Phone: _____

Date: _____ **Please use reverse side for further remarks.**

I, _____, confirm 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 Keeneyville School District #20 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, while under the supervision of the employee and agents of the School District), lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree 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. 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 or attempts at administration of said medication.

Signature of parent/guardian _____

Date _____