



School Medication Authorization Form

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: _____ (4/11)

Medication/treatment orders are included in attached plan.

Greenbrook
Donna Zajic, LPN
Phone 630-894-4409
Fax 630-289-1063

DISTRICT HEALTH SERVICES
Spring Wood
Maureen Stralina, RN, BS
Phone 630-894-4044
Fax 630-894-9658

Waterbury
Barb Orozen
Phone 630-894-4211
Fax 630-893-3797



I, _____ (parent), 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.

(PARENT'S/GUARDIAN'S SIGNATURE)

(DATE)

(4/11)

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