WEST AURORA SCHOOL DISTRICT NO. 129

SCHOOL MEDICATION AUTHORIZATION FORM
TO ADMINISTER REQUIRED MEDICATIONS DURING SCHOOL HOURS

STUDENT'S NAME: ______________________________________ GRADE: ____ BIRTHDATE:____________

ADDRESS: ____ PHONE:_________________

EMERGENCY CONTACT NAME AND PHONE NUMBER: ____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I _______________________________ parent/guardian of ________________________ hereby authorize West Aurora School District #129, and its employees and agents, on my behalf and in my stead, to administer to my child lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I will bring the medication to the school's health office in a container appropriately labeled by the pharmacy. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage is changed. I understand that it is the responsibility of the student to report to the health office at the scheduled time to receive the medication.

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 that administration of said medication. In addition, I agree to indemnify and hold harmless the school district, 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 of said medication, except a claim based on willful or wanton conduct.

Parent/Guardian Signature: ____ Date: ______________

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis:____Name of Medication:___________________________

Dosage:_______________________________ Route of Administration: ___________________________________

Time/Circumstances when Medication Should be Administered: ____

Side Effects: ____

Date of Prescription: _____________________________ Discontinuation Date: ____________________________

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

___________________________________	___________________________________	
Phone Number of Physician	Signature of Physician	Date
___________________________________	___________________________________	
Address of Physician	Print Name of Physician	Date