Updated 09/2019

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 Signature: ____

Physician's name – print: ____

Address: ____

Office Phone: _______________________________ Emergency Phone: __________________________

Date: _______________

☐ **Medication/treatment orders are included in attached plan.**

(R-05-17)

DISTRICT 20 HEALTH SERVICES

Greenbrook Elementary School
& Early Childhood Center
630-894-4409 Nurse Phone
630-894-4544 Main Office
630-289-6183 Fax

Waterbury Elementary School
630-894-4211 Nurse Phone
630-893-8180 Main Office
630-539-2316 Fax

Spring Wood Middle School
630-894-4044 Nurse Phone
630-893-8900 Main Office
630-894-9658 Fax

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)

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