



# Medication Authorization Form

Year \_\_\_\_\_

Student Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**

**\*Diagnosis for Medication:\*** \_\_\_\_\_

Medication Name	Dose	Time To Be Given *If PRN please indicate how often medication can be given*	Route	Side Effects	Special Instructions (Such as "take with food" or "crush pill")

Start Date: \_\_\_\_\_

Stop Date: \_\_\_\_\_

If **PRN** (as needed) list symptoms /conditions under which medication is to be given: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Printed Name

**To be completed by parent/guardian:**

I am giving permission for my child \_\_\_\_\_ to receive the above medication/treatment at school according to school district policy and for the physician and school district staff to share information regarding my child's medication needs.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Please turn completed and signed form into office when completed.



**POLICY CONCERNING ADMINISTRATION OF**

**MEDICATIONS/MEDICAL PROCEDURES BY SCHOOL DISTRICT PERSONNEL**

**HOLD HARMLESS AND INDEMNIFICATION**

In consideration of the agreement of persons at the District to administer medication and/or medical procedures to \_\_\_\_\_  
\_\_\_\_\_, as requested by me and prescribed by a physician. I, on my own behalf, and on behalf of any  
other person associated with me, hereby agree to hold harmless and indemnify the Southgate Community School District, its Board of  
Education members, administrators, teachers, secretaries, and other employees, from any and all claims, damages, liabilities,  
demands, actions, causes of action, which may hereafter be asserted by any person, corporation, or other entity, against the parties  
listed above or against any other person associated with the Southgate Community School District under any legal theory based upon  
or arising out of circumstances related in any way to administration, by the District personnel, of medications or medical procedures  
to \_\_\_\_\_.

Witnesses:

\_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Telephone No. (Home)

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Emergency Contact Number