Medication/Diagnosis Authorization Form

Student Name: ________________________ Birth date: ____________
Address: _____________________________ Phone: _______________
Grade: ____________ Teacher: ________________________________
Emergency Contacts Name & Number:
Mother: __________________________ Father: ____________________________
Other: ___________________________

I hereby authorize Fremont School District 79 and its employees and agents on my behalf to administer to my child lawfully prescribed medication in the manner described below. 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 the administration of said medication. In addition, I agree to 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 incurred or resulting from the administration of said medication.

If self administration is authorized by the student's physician and parent, the School shall be under no obligation to notify or remind a student when medication should be administered. It shall be solely the student's responsibility to obtain the medication from authorized personnel at the time of administration. The School Nurse/Health Clerk or Administration shall retain the medication in a locked space for safe storage. The prescribed medication will be available to the student for self administration at the times designated by the physician's written orders.

____ __________________
(Parent/Guardian Signature) (Date)

To be Completed by Physician

Type of Diagnosis (Please give specific on back of sheet): ______________________
Name of Medication: ____
Dosage: ______________________________ Time: _______________________
Duration of Medication: ____
Child Will Self Administer Medication (Check yes or no) _______Yes ______ No
Side Effects of Prescribed Medication: _____________________________________
____
____

Doctor's Name: _____________________ Phone Number ______________________
Doctor's Signature: _________________________________ Date: _______________

Diagnosis Form

To be Completed by Physician
Student's Name ___________________________________
Type of Diagnosis _________________________
Doctor's Name: _______________________
Phone Number _______________________
Doctor's Signature: ___________________________________
Date: _________________

Details of Diagnosis:

Medications Needed (Please list at home/ at school/ or both):

Severity of Diagnosis (Is this or could this be a Life-Threatening Diagnosis):