School Medication Authorization for Prescription Medication

(to be filled out by parent)

Student's Name _____ Birth Date_____

Address_____

Home Phone_____ Other/emergency phone _____

School_____ Grade _____

By singing below I agree to hereby authorize the school district and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), prescription medications in the manner described below. I acknowledge that it may be necessary for the administration for the medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and I agree to indemnify and hold the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. I also understand that prescription medication must be kept in the **original** prescription container with the child's name legible.

Parent Name _____

Signature _____ Date_____

(to be filled out by physician and/or physician's office)

Physician's name _____

Office phone _____ fax(if available)_____

Medication Name _____

Dosage _____ Frequency _____

Side effects _____

Is it necessary for this medication to be administered during the school day? Yes or No

_____

(Physician's signature)