# GOWER SCHOOL DISTRICT 62 MEDICATION AUTHORIZATION FORM

(To be completed annually and placed in the school health office)

Student Name_____Birth date _____

Address_____

Home Telephone _____ Emergency Telephone _____

School_____Grade _____ Teacher _____

(TO BE COMPLETED BY TREATING/PRESCRIBING PHYSICIAN)

Physician's Printed Name _____

Office Address _____

Office Phone _____ Emergency Telephone _____

Diagnosis Requiring Medication _____

Medication is required to be administered during the school day □ YES □ NO

| Name of Medication | Dosage | Frequency | Time to Administer | Duration | Side Effects |
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□ The student named above may self-administer his/her medication on field trips and/or other off-campus school sponsored programs, activities, or events. I certify that he/she has been properly instructed in its use. **(Inhalers ONLY)**

□ The student named above may carry and self-administer his/her asthma medication. I certify that he/she has been properly instructed in its use.

Physician Signature _____ Date_____

PARENT AUTHORIZATION

I hereby 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 Gower School District 62 and its designated employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the designated employees and agents of the District), lawfully prescribed medication in the manner described above. 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 District, its employees and agents, arising out of the administration of, or attempt to administer, such medication. in addition, I agree to hold harmless and indemnify the District, its employees and agents, jointly and severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of, or attempt to administer, such medication.

In the event that the District designated personnel observe an overuse or dependency upon medications, the parents will be contacted and procedures reviewed and modified as appropriate.

Parent/Guardian Signature_____Date _____