SPECIAL EDUCATION DISTRICT OF LAKE COUNTY
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Valerie M. Donnan, M.Ed.
Superintendent

MEDICATION & TREATMENT AUTHORIZATION FORM

Medications cannot be administered at school without a doctor's written order and a written request from the parent or guardian.

School:_____

Student Name:_____ Birth Date:_____

Parent/Guardian Name:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PHYSICIAN:

Medication/Treatment (1):_____ Dosage: _____ Route: _____

Time interval to be taken:_____ Duration: _____

Possible side effects:_____

Condition for which medication is being given: _____

Must this medication be administered during the school day in order to allow child to attend school or to address the child's medical condition? ☐ Yes ☐ No

Medication/Treatment (2):_____ Dosage: _____ Route: _____

Time interval to be taken:_____ Duration: _____

Possible side effects:_____

Condition for which medication is being given: _____

Must this medication be administered during the school day in order to allow child to attend school or to address the child's medical condition? ☐ Yes ☐ No

Physician's Signature: _____ Date: _____

Physician's Name:_____ Office Phone:_____ FAX:_____
PLEASE PRINT

TO THE PARENT/GUARDIAN:

All medications to be taken at school must be supplied by the parent per SEDOL policy. This request terminates at the end of the physician's prescribed orders or the end of the current school year, whichever occurs first. SEDOL Nursing may consult with the prescribing physician regarding school medication.

By signing below, I agree 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 SEDOL and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of SEDOL), lawfully prescribed medication in the manner described by the physician. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a SEDOL nurse and specifically consent to such practices**, and I agree to indemnify and hold harmless SEDOL 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 hereby request and grant permission for professional school personnel to administer the above prescribed medication(s) to my child during the school day.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

cc: SEDOL Nurse
Central File
Student ID# _____