Nurse Phone: 708.467.5647 **Nurse Fax: 708.467.5672**

ARGO COMMUNITY HIGH SCHOOL MEDICATION AUTHORIZATION FORM

(To be completed ANNUALLY and kept in the school health office)

Student Name _____ Birthdate _____ ID # _____

Parent/Guardian _____

Phone _____ Emergency Phone _____

MEDICATION INFORMATION, INCLUDING OVER-THE-COUNTER

This Section must be completed and signed by either: (1) the student's physician; (2) physician assistant; or (3) advanced practice registered nurse.

Physician's Name _____

Office Address _____

Office Phone _____ Emergency Phone _____

Diagnosis Requiring Medication _____ Any Known Allergies _____

Intended Effect of Medication _____ Re-Evaluation of Medication/Effect _____

Other Medications Taken _____

Medication is required to be administered during school day YES NO

Name of Med	Dosage/Rt	Frequency	Time to Admin	Duration	Side Effects

(**Epinephrine Auto-Injector ONLY):** The student named above may (check those that apply)____self-administer, ___self-carry his/her epinephrine auto-injector at school and school-related events. I certify that he/she has been properly instructed in its use. ____(initial to indicate agreement)

Physician Signature _____ Date _____

Parent/Guardian Authorization/Signature

I agree to indemnify and hold harmless the Board of Education of Argo Community High School District #217 ("School District"), including officers, employees, agents, servants, independent contractors, and volunteers, and their successors and assigns, in their individual and official capacities from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnitees and arising out of a claim related directly or indirectly to my son/daughter's use of medication. I understand that the School District and the foregoing individuals are to incur no liability as a result of any injury arising from the use of medication, regardless of whether authorization was given by my student's parents or guardians or by my student's physician, physician's assistant, or advanced practice registered nurse, provided, however, this indemnity and hold harmless commitment does not apply to the willful and wanton conduct of the foregoing indemnitees.
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 the School District and its employees, on my behalf and stead, to administer or attempt to administer (or to allow my child to self-administer for asthma medication or epinephrine auto-injector only with above authorization) this lawfully prescribed medication and any prescribed changes. I acknowledge that it may be necessary for the administration of medication to my child be performed by an individual other than a school nurse (i.e. school administrator). 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 School District and indemnify the School District and its employees from any and all claims, damages, and causes of action or injury incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Signature _____ Date _____