



SCHOOL MEDICATION AUTHORIZATION FORM

School Year: _____

Fax number: _____

A separate form must be completed for EACH medication.

The following to be completed by the PARENT or GUARDIAN:

Student's name: _____ Date of birth: _____

Address: _____ Phone: _____

School: _____ Grade: _____

EMERGENCY CONTACT: Name: _____

Phone: _____ Relationship to child: _____

- I understand that I am to bring in the medication to the school office in a pharmaceutical container labeled with the student's name, name of the medication, dosage and all pertinent instructions.
- I hereby release School District 15, its officers, directors, agents, employees and assigns from any and all liability arising from the administration of medication to the above-named student.
- I also acknowledge that the School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of the medication. I agree to indemnify and hold harmless the School District and its employees and agents against any and all claims, except claims based on willful and wanton conduct, arising out of the self-administration of medication by the student.

FOR ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR:

I give permission for my child to carry his/her inhaler and/or epinephrine auto-injector and be responsible in its use, provided the doctor gives consent for the same.

Check one _____ Yes _____ No

Parent/Guardian Signature: _____ Date: _____

The following must be completed by HEALTH CARE PROVIDER:

Name of medication: _____ Dosage: _____

Medication instructions: _____

Purpose of medication/Diagnosis: _____

Possible side effects: _____

If applicable, may student carry inhaler and/or epinephrine auto-injector? YES NO

The student is presently under my care. I believe that the failure of the student to receive the medication referenced herein, which I have prescribed, during the school day, would jeopardize the student's health and education.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____ Fax: _____



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Se debe completar un formulario por separado para CADA medicamento.

EL PADRE, MADRE O TUTOR debe completar lo siguiente:

Nombre del estudiante: _____ Fecha de nacimiento: _____

Dirección: _____ Teléfono: _____

Escuela: _____ Grado: _____

CONTACTO DE EMERGENCIA: Nombre: _____

Teléfono: _____ Parentesco con el niño: _____

- Entiendo que debo llevar el medicamento a la oficina de la escuela en un envase farmacéutico etiquetado con el nombre del estudiante, el nombre del medicamento, la dosis y todas las instrucciones pertinentes.
- Por la presente, libero al Distrito Escolar 15, sus funcionarios, directores, agentes, empleados y cesionarios de toda responsabilidad derivada de la administración del medicamento al estudiante mencionado anteriormente.
- También reconozco que el Distrito Escolar y sus empleados y agentes no incurrirán en ninguna responsabilidad, excepto por conducta deliberada e imprudente, como resultado de cualquier lesión derivada de la autoadministración del medicamento por parte del estudiante. Acepto indemnizar y eximir de responsabilidad al Distrito Escolar, a sus empleados y agentes, contra cualquier reclamación, excepto las basadas en conducta deliberada e imprudente, derivada de la autoadministración de medicamentos por parte del estudiante.

PARA MEDICAMENTOS PARA EL ASMA Y/O AUTOINYECTOR DE EPINEFRINA:

Autorizo a mi hijo/a a llevar consigo su inhalador y/o autoinyector de epinefrina y a ser responsable de su uso, siempre que el médico lo autorice.

Marque una opción Sí No

Firma del padre/madre/tutor: _____ Fecha: _____

The following must be completed by HEALTH CARE PROVIDER:

Name of medication: _____ Dosage: _____

Medication instructions: _____

Purpose of medication/Diagnosis: _____

Possible side effects: _____

If applicable, may student carry inhaler and/or epinephrine auto-injector? YES NO

The student is presently under my care. I believe that the failure of the student to receive the medication referenced herein, which I have prescribed, during the school day, would jeopardize the student's health and education.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____ Fax: _____