



Medication/Diagnosis Authorization Form

Student Name: _____ **Birthdate:** _____

Address: _____ **Phone:** _____

Grade: _____ **Teacher:** _____

I hereby authorize Fremont School District 79 and its employees and agents on my behalf to administer to my child lawfully prescribed medication in the manner described below. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

If self-administration is authorized by the student's physician and parent, the School shall be under no obligation to notify or remind a student when medication should be administered. It shall be solely the student's responsibility to obtain the medication from authorized personnel at the time of administration. The School Nurse/Health Clerk or Administration shall retain the medication in a locked space for safe storage. The prescribed medication will be available to the student for self-administration at the times designated by the physician's written orders.

(Parent/Guardian Signature)

(Date)

To be Completed by Physician:

Name of Medication: _____

Dosage: _____

Time: _____

Duration of Medication: _____

Child Will Self-Administer Medication (Check yes or no) _____ **Yes** _____ **No**

Child May Self-Carry Medication (Check yes or no) _____ **Yes** _____ **No**

Side Effects of Prescribed Medication:

Doctor's Name: _____

Phone Number: _____

Doctor's Signature: _____ **Date:** _____



Diagnosis Form

To be Completed by Physician

Student's Name: _____

Type of Diagnosis: _____

Doctor's Name: _____

Phone Number: _____

Doctor's Signature: _____

Date: _____

Details of Diagnosis:

Medications Needed (Please list at home/ at school/ or both):

Severity of Diagnosis (Is this or could this be a Life-Threatening Diagnosis):