Central
36414 N Ridge Rd
Ingleside, IL 60041

P: 847.973.3280
F: 847.496.8922

Gavin School District 37

South
25775 W. Highway 134
Ingleside, IL 60041

P: 847.546.9336
F: 847.496.8703

Medication Authorization Form

Name:_____ Birthdate:_____Grade:_____

To be Completed by Authorizing Physician

Only those medications that are absolutely necessary for the critical health and well being of the student will be administered during school hours. I hereby authorize employees of Gavin School District #37 to act on my behalf in administering the following medication during school hours.
Medication as used in this document will refer to both prescription and non- prescription drugs.

Medication:_____ Dosage:_____

Diagnosis:_____

Medication side effects:_____

Start Date:_____ Daily/Temp./PRN:_____ End Date:_____

Time of Administration:_____If PRN state time between doses:_____

Physician Printed Name:_____ Signature:_____

Physician's Phone #:_____ Address:_____

To be completed by Parent/ Guardian

I have read the school policy concerning medication administration during the school day. I understand that failure to follow the regulations will result in the school district being unable to honor my request for medication to be administered to my child.

I give permission for my child _____to receive the above medication as prescribed. I understand that my signature on this form constitutes a waiver by me to the school district, its Board, officers, and other personnel as to any claim, suit, damages it may be called on to pay or defend in connection therewith. I also understand that my signature on this form denotes permission for the school health official and prescribing physician to confer regarding the administration and monitoring of medication.

Parent/ Guardian Signature:_____

Daytime Phone#: _____ Date:_____

All medications must be transported to school by parent/ guardian- unless other arrangements are made with the school nurse, principal, or principal's designee prior to transportation.