Bannockburn School District 106
Medication Authorization

*A new form must be completed every school year. Multiple medications each require their own form.*

Student Name: _____ Date of Birth:_____

Address: _____ Phone: _____

*To be completed by the student's physician, physician assistant, or advanced practice nurse*

Medication Name: _____ Dose: _____ Route:_____

Time, frequency, or circumstances, medication is to be administered at school:

_____

Diagnosis requiring medication:_____ Purpose:_____

Possible side effects: _____

Other medication student is receiving:_____

**Physician Name:** _____ **Phone:** _____

**Physician Address:** _____ **Fax:** _____

**Physician Signature:** _____ **Date:**_____

*For all parents/guardians:*
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 the School District 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 the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices; and I agree to indemnify and hold harmless the School District 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.

_____ _____
Parent/Guardian printed name Parent/Guardian printed name

_____ _____
Parent/Guardian signature* Date Parent/Guardian signature* Date

- Both parents and/or guardians, if available, should sign.