BUILDING RELATIONSHIPS WITH TOMORROW'S LEADERS
WE ARE SD81
CONNECT • EMPOWER • INSPIRE

MEDICATION AUTHORIZATION FORM

Student Name		**Date of Birth**	
Address		**Grade**	
City, State, Zip		**Phone**	

The following is to be filled out by the Physician

Medication			
Dosage		**Route**	
Time to be administered		**Duration of administration**	
Diagnosis			
Side Effects (if any)			

Emergency Medication: EPI PENS and RESCUE INHALERS ONLY. MD must initial choice

_____ Student may carry this medication on his/her person.
(It is recommended that "back up" medication be stored in the nurse's office.)

_____ Student may self-administer medication. I have instructed the student on the administration of this medication and find that he/she is able to administer this medication independently.

_____
Physician's Name (Please Print) **Phone**

_____
Address **City** **State** **Zip**

_____
Physician's Signature **Dat**

Parent/Guardian Authorization

Schiller Park School District 81 and its employees and agents, are hereby authorized to administer to the above named student or to allow the self-administration of lawfully prescribed medications described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims against the School District and its employees, which might arise out of the administration of said medication. In addition, I agree to indemnify and 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from administration of said medication.

_____
Signature of Parent or Legal Guardian **Date**

CC: ☐ Teacher ☐ PE/Coach ☐ Cafeteria MGR

_____
Reviewed by School Nurse: **Date**