School Medication Authorization Form

Student's Name _____ Birth Date _____

Address _____ _____ _____ _____
Street City State Zip

Home Phone _____ Emergency Phone _____

To be completed by the student's physician

Name of Medication _____

Dosage _____ Frequency _____ Time to be given in school _____

Prescription Date _____ Order Date _____ Discontinuation Date _____

Diagnosis requiring medication _____

Intended effect of this medication _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? Yes No

Expected side effects, if any _____

Time interval for re-evaluation _____

Other medications student is receiving _____

_____ _____ _____
Physician's Signature Physician's Name (please print) Date

Address _____ _____ _____ _____
Street City State Zip

Office Phone _____ Emergency Phone _____

I confirm 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 Fairview South School and its employees and agents, in my behalf and stead, 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 Fairview South School), 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.** I further acknowledge and agree that, when the lawfully prescribed medication is so administered , I waive any claims I might have against Fairview South School, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Fairview School District 72, 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 or attempts at administration of said medication.

Parent(s)/Guardian(s) signature _____ Date _____

Parent(s)/Guardian(s) name (please print) _____