



SCHOOL MEDICATION AUTHORIZATION FORM

**MEDICATIONS CANNOT BE ADMINISTERED AT SCHOOL WITHOUT A DOCTOR'S
WRITTEN ORDER AND A WRITTEN REQUEST FROM THE PARENT OR GUARDIAN**

Name of Student _____ Date of Birth _____
Address _____
_____ Emergency Phone _____
School _____ Grade _____

Part I – Physician's Statement

- 1.) Name/type of medication _____
- 2.) Dosage/amount to be given _____
- 3.) Route of administration _____
- 4.) Frequency and time of administration _____
- 5.) Diagnosis _____
- 6.) Intended effect and anticipated reaction to medication _____

- 7.) Side Effects _____
- 8.) Other medication child is receiving _____
- 9.) Other requirements _____
- 10.) Must this medication be administered during the school day in order to allow the student to attend school?

Physician's Signature

Date Signed

Address

Telephone No.

Part II – Parent's Request/Approval

I hereby request and grant permission for School District 23 personnel to dispense medication to my daughter/son _____, according to the above instructions. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration of said medication and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severely, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the administration of medication.

Signed _____ Phone No. _____ Date _____