Marion Community Unit School District No. 2

SCHOOL MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT /GUARDIAN

STUDENT'S NAME: _____ **DOB:** _____

ADDRESS: _____ **PHONE NUMBER:** _____

NAME OF MEDICATION: _____ **DOSAGE:** _____

NAME OF DOCTOR & FACILITY: _____

ALL MEDICATIONS TO BE GIVEN AT SCHOOL MUST BE IN THE ORIGINAL CONTAINER

I hereby authorize Marion Community Unit School District No. 2 and its employees and agents, in my behalf and stead, 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 by a physician. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damage, causes of action or injuries incurred or resulting from the administration of said medication.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

TO BE COMPLETED BY STUDENT'S PHYSICIAN

NAME OF MEDICATION: _____ **DOSAGE:** _____ **TIME:** _____

REASON FOR MEDICATION: _____ **DURATION OF ADMINISTRATION:** _____

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? _____ **Side effects to be alert to:**

_____

DOCTOR'S NAME (PLEASE PRINT) _____

DOCTOR'S SIGNATURE: _____

OFFICE ADDRESS: _____

PHONE NUMBER: _____ **DATE:** _____

Further instructional remarks: _____

☐ **Self-administration and self-carry of inhaler and/ or epinephrine**

☐ **Self-carry ONLY of inhaler and /or epinephrine (administration by nurse/designee)**

☐ **Inhaler and/ or epinephrine to be kept in nurse's office**

SCHOOL: _____ GRADE: _____ TEACHER: _____