Marion Community Unit School District No. 2

School Medication Authorization Form

To be completed by the child's parent/guardian.

Student's name: _____ Birth Date: _____
Address: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Teacher/Grade: _____

I hereby request and authorize Marion CUSD No. 2 and its employees and agents, in my behalf and stead, to administer my child (or 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 below. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a 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 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, damages, causes of action or injuries incurred or resulting from the administration of said medication. It is my responsibility to provide the school office with the medication dosage changes in writing from the licensed prescriber. I authorize communication between the school nurse, building principal/designee and the licensed prescriber below in the care of my child in the school setting.

Must be completed by the licensed prescriber:

Name of medication/health care treatment: _____
Dosage: _____ Time to be administered: _____
Duration of Administration: _____
Type of disease or illness: _____
Side effects to be alert for: _____
Other medications student is receiving: _____
_____

May student carry the medication on their person and self-administer medication during school hours/school activities? **Please circle**: Yes No
If yes: I certify that _____ has been instructed in the use and self-administration of _____. He/she understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Licensed Prescriber's printed name: _____ Phone: _____
Licensed Prescriber's signature: _____ Date: _____
Licensed Prescriber's address: _____ Fax: _____