AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Auburn Community Unit School District #10

Phone (217)438-6164 Fax (217)438-6483

The following section is to be completed by the **Physician**.

Student's Name _____ Date of Birth _____

Name of Medication _____

Dosage_____ How administered _____

Time of administration at school _____

If the medication is to be given on an "as needed" basis, how soon it can be repeated?_____

Diagnosis for which the medication is required to be given at school_____

Possible side effects _____

_____ _____
Physician's signature Date

_____ _____
Physician's name (please print) Phone

_____ _____
Address Fax

The following section is to be completed by the **PARENT**:

Student's name _____ Grade _____ Date of Birth _____

I request that the above named medication be administered to my child as instructed by the physician. I hereby authorize Auburn School District #10 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of said medication 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 or attempted to be administered, I waive any claims I might have against the Auburn School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the Auburn 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 or attempts at administration of medication. I also understand and will comply with the requirements for sending medication to school in the original unopened container from the manufacturer which is properly labeled with my child's name. I understand that it is my responsibility to see that the medication arrives at school in a safe manner. I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

_____ _____
Parent / Guardian Signature Date

_____ _____
Address Phone

_____ _____
Emergency Contact Person Phone