SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME ______________________________
ADDRESS ______________________________________
TELEPHONE 4 _____________________
BIRTHDATE ___________ ___________ .
SCHOOL __________________________________ GRADE ___
EMERGENCY TELEPHONE NUMBER _______________

I, __________________, parent or guardian of ________________, hereby authorize Durand Community Unit District No. 322, and its employees and agents, in my behalf and stead, to administer to 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 further acknowledge and agree that, when the lawfully prescribed medicine 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 indemnify and hold harmless the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

______________________________ ______________________
Parent or Guardian Signature Date

(To Be Completed by the Student's Physician)

Name of Medication _______________________________
Dosage ____ Administration Time _______________
Duration of Medication ____
Type of Disease or Illness: ___________________________________
Must this medication be administered during the school day in order to allow the child to attend school? ___ yes ___ No
Are there any side effects from the medication? ___ Yes ___ No
If yes, please specify: ____

_________________________ _________________________
Doctor's Name (Print) Doctor's Signature
Emergency Telephone # ___________

____
Adddress

____
Telephone #

Daily Medication Administration Record

Student: ______________________ School Year: ______________ School ______________________

Date of Birth: __________ Teacher: ________________ Diagnosis: ______________________

Medication, Route: ______________________ Date, Dose, Time: ______________________

Parent Name: ______________________ Physician: ______________________

Parent Phone: ______________________ Physician Address: ______________________

Comments: ______________________ Physician Phone: ______________________

Please put the time and your initials in appropriate box.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPTEMBER																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															
JULY																															

INITIAL	NAME
________	______________________
________	______________________
________	______________________
________	______________________

CODES

_ : Weekend

H : Holiday

A : Absent

N : None Available

*: Bottle home

Δ : Change in routine - see notes

F : Field Trip

D : Early Dismissal

W : Dose Withheld

O : No Show