BEMENT COMMUNITY UNIT SCHOOL DISTRICT #5

Fax No. 217-678-4251

SCHOOL MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT /GUARDIAN:

STUDENT'S NAME: ____ BIRTH DATE: ________________

ADDRESS: ____ TEACHER: ___________________

HOME PHONE: ____________________________ EMERGENCY PHONE: __________________________

SCHOOL:____GRADE: __________________________

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Bement Community School District #5 and its employees and agents, in my behalf and stead, to administer or to attempt 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 our physician. 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 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication. I also understand that the school may contact the physician if there are problems regarding this medication. (This includes psychiatric medications prescribed to be taken during school hours.)

Parent Signature____ **Date**_______________________

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Physician's Printed Name: ___________________________________Office Phone: ____________________

Office Address: ____Emergency Phone:_________________

Medication ____________________________ Dosage: _____________Frequency:______________________

Time Medication is to be administered or under what circumstances: ___________________________________

Prescription Date:____________________________ Discontinue Date:__________________________________

Diagnosis requiring medication: ____

Intended effect of this medication: ____

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? Please circle: Yes No

Expected Side Effects, if any: ____

Other medication student is receiving, if any: ____

Physician Signature____**Date**________________________

NOTE: <u>ALL MEDICATION MUST BE IN CORRECTLY LABELED PHARMACY CONTAINERS!</u>