AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL BY SCHOOL PERSONNEL

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Principal's office.

STUDENT'S NAME_________________________________ DATE OF BIRTH______________________________

PARENT/GUARDIAN________________________________ HOME PHONE________________________________

ADDRESS______________________________________ GRADE/SCHOOL______________________________

EMERGENCY CONTACT NAME AND PHONE NUMBER: ____

I. TO BE COMPLETED BY THE PHYSICIAN

To be completed by the student's physician, physician assistant, or advanced practice nurse:

Name of Medication ____________________Administration Route____________ Dosage______________________

Time/Frequency/Circumstances when Medication Should be Administered ______________________________

Student's Diagnosis____

Possible Side Effect(s)____

Actions to be taken if the student has side effects and/or an adverse reaction to the medication:

____

Intended Effects of this Medication____

Date of Prescription_______________________________ Discontinuation Date________________________

Other medications student is receiving: ____

Is it absolutely necessary that this medication be administered in school? Yes_____ No______

***The physician must authorize changes in dosage of any medications in writing.**

____________________	______________________	__________	______________
PHYSICIAN'S NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE	PHONE

II. TO BE COMPLETED BY THE STUDENT'S PARENT OR GUARDIAN

By signing below, I, ______________________, parent/guardian of _________________, confirm that I have reviewed and understand IPSD 204's Policy regarding the administration of medication in school. I understand that I am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize IPSD 204 and its employees and agents, on my behalf and in my stead, to administer or attempt to administer lawfully prescribed medication in the manner described above pursuant to State law. **I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.** I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the current school year and will need to be renewed each subsequent school year.

I further acknowledge and agree to waive any claims I might have against IPSD 204, its employees and agents arising out of the administration or attempted administration of said medication. In addition, I agree to hold harmless and indemnify IPSD 204, 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, except a claim based on willful and wanton conduct, arising out of, incurred or resulting from the administration or attempted administration of said medication regardless of whether the authorization was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Finally, I understand and agree that it is my responsibility according to IPSD 204 policy to deliver the legally prescribed medication to the school, and pick up any remaining medication at the end of the school year from the school, myself or via another adult designee.

Parent/Guardian Signature____ Date__________________________