District 115
YORKVILLE
Community Unit School District
Administrative Center · 602 Center Parkway · Yorkville, Illinois 60560 · 630-553-4382 · y115.org

Authorization and Permission for Administration of Medication

Student's Name: _____ School: _____

Address: _____ Birthdate: _____ Grade: _____

PARENTAL AUTHORIZATION

School medications and health care services are administered following these guidelines:

(1) Authorization and Permission for Administration of Medication form is signed and dated by parent and physician
(2) The medication label contains the student's name, name of the medication, and directions for administration
(3) All medications are delivered to school and picked up from school by the parent or other responsible adult

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of a medical emergency, I authorize Yorkville Community Unit School District 115 and its employees and agents, on my behalf, to administer or to attempt to administer to my child, or allow my child to self-administer, the lawfully prescribed medication in the manner described in this authorization form. I acknowledge that it may be necessary for the medication to be administered to my child by an individual other than a school nurse, and I specifically consent to such practices. Additionally, I waive any claims I might have against District 115, the Board of Education and its members, its employees, and its agents arising out of the administration or attempt to administer to my child or my child's self-administration of the medication(s). I also agree to hold harmless and indemnify District 115, the Board of Education and its members, its employees, and its agents from and against any and all claims, demands, damages, causes of action, injuries, costs, and/or expenses, including attorney's fees, resulting from or arising out of the administration or attempt to administer to my child or my child's self-administration of the medication(s).

_____
Parent's Name (printed) Signature Phone (day) Phone (evening)

_____
Emergency Contact (other than the parent) Relationship to the Student Phone

PHYSICIAN AUTHORIZATION

Diagnosis/Purpose: _____

Is this medication necessary for the student to take during the school day in order to attend school? Yes No

Start Date	**Discontinue Date**	**Medication**	**Dosage**	**Medication administration Time / Method** (e.g., mouth)	**Additional Instructions & Expected Side Effect** (if any)

Physician's Name (printed/stamp) _____ Physician's Signature _____

Phone: _____ Date: _____