

JOHNSBURG COMMUNITY UNIT SCHOOL DISTRICT 12
SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME _____ BIRTHDATE _____
ADDRESS _____ HOME PHONE _____
SCHOOL _____ GRADE _____ TEACHER _____

To be completed by the student's physician:

NAME OF MEDICATION _____

DOSAGE _____ TIME _____

DURATION OF ADMINISTRATION _____

TYPE OF ILLNESS OR DISEASE _____

MUST THIS MEDICATION BE TAKEN DURING THE SCHOOL DAY IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL OR TO ADDRESS THE STUDENT'S MEDICAL CONDITION? _____

SIDE EFFECTS TO BE ALERTED TO: _____

Doctor, please "X" either A or B:

- A. This student, being mature and responsible, may self administer this prescribed medication. The student will transport, store and consume this medication. _____
- B. This student must have this prescribed medication administered by the School Nurse/Certified Licensed Designee of the school. _____

(DOCTOR'S NAME - PRINT)

(ADDRESS)

(DOCTOR'S SIGNATURE)

(DATE)

(DOCTOR'S PHONE)

(DOCTOR'S FAX)

FURTHER INSTRUCTION/REMARKS: _____

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 Johnsburg School District 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 lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY THE SCHOOL NURSE, RN, LPN, ADMINISTRATOR, OR STAFF HOLDING VALID TEACHING CERTIFICATE, 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 School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Johnsburg 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 said medication. Signing this form gives District 12 permission to call the doctor to clarify information about the medication.

(PARENT'S SIGNATURE)

(DATE)