REQUEST FOR THE ADMINISTRATION OF MEDICINE

MEDICATIONS CANNOT BE ADMINISTERED AT SCHOOL WITHOUT A DOCTOR'S WRITTEN ORDER AND A WRITTEN REQUEST FROM THE PARENT OR GUARDIAN

Name of Student _____ Date of Birth _____

Address _____ Emergency Phone _____

_____

School _____ Grade _____

Part 1 – Physician's Statement

1.) Name/type of medication _____

2.) Dosage/amount to be given _____

3.) Route of administration _____

4.) Frequency and time of administration _____

5.) Diagnosis _____

6.) Intended effect and anticipated reaction to medication _____

_____

7.) Side Effects _____

8.) Other medication child is receiving _____

9.) Other requirements _____

10.) Must this medication be administered during the school day in order to allow the student to attend school?

_____

Physician's Signature _____ Date Signed _____

Address _____ Telephone No. _____

Part II – Parent's Request/Approval

I hereby request and grant permission for School District 23 personnel to dispense medication to my daughter/son _____, according to the above instructions. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration of said medication and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severely, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney's fees, resulting from or arising out of the administration of medication.

Signed _____ Phone No. _____ Date _____

8/02