

**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL**

**PAWNEE COMMUNITY UNIT SCHOOL DISTRICT #11**

**PHONE: 625-2231**

**FAX: 625-2251**

The following section is to be completed by the PARENT:

**STUDENT'S NAME** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

I confirm that I am responsible for administering medication to my child. However, in the event that I am unable to do so during school hours, I hereby authorize Pawnee School District #11 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, 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 Pawnee School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the Pawnee 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 medication.

\*\*\*I also understand and will comply with the requirements for sending medication to school in the original and current prescription bottle from the pharmacy which is properly labeled with child's name, name of medication and dosage, instructions for administration, date of prescription, prescribing physician, and name of pharmacy and pharmacist. I understand that it is my responsibility to see that the medication arrives at school in a safe manner. I also understand that noon/lunch medication is not routinely administered on 12:00 dismissal days, nor is morning doses of medication given at school and medication is not sent on field trips. I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

_____	_____
Parent/Guardian Signature	Date
_____	_____ / _____
Address	Home Ph      Work Ph/Cell
_____	_____
Emergency Contact Person	Phone

The following section is to be completed by the PHYSICIAN:

**NAME OF MEDICATION** \_\_\_\_\_

**DOSAGE** \_\_\_\_\_ **TIME OF ADMINISTRATION AT SCHOOL** \_\_\_\_\_

**DIAGNOSIS** for which the medication is required to be given at school \_\_\_\_\_

**EXPECTED SIDE EFFECTS**, if any: \_\_\_\_\_

**\*\*If the medication is an inhaler, please provide the following:**

**KNOWN TRIGGERS** \_\_\_\_\_

**PEAK FLOW RANGES/ZONES** \_\_\_\_\_

If the medication is to be given on an "as needed" basis, how soon it can be repeated? : \_\_\_\_\_

_____	_____
Physician's Signature	Date
_____	_____
Physician's Name – please print	Phone
_____	_____
Address	Fax