

**HARVARD COMMUNITY UNIT SCHOOL DISTRICT #50**

**MEDICATION AUTHORIZATION FORM**

401 North Division St, Harvard Il 60033 Phone 815-943-4022 Fax 815-943-8511



***Fill out only if taking medication at school.***

STUDENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SHOOOL YEAR \_\_\_\_\_

ADDRESS \_\_\_\_\_ Primary PHONE(s) \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_

**TO BE COMPLETED BY STUDENT'S PHYSICIAN- MEDICATION CANNOT BE GIVEN WITHOUT THIS PORTION:**

MEDICATION \_\_\_\_\_ PURPOSE \_\_\_\_\_

DOSAGE \_\_\_\_\_ ROUTE \_\_\_\_\_ TIME \_\_\_\_\_ FREQUENCY \_\_\_\_\_

DURATION (DATES) OF MEDICATION (max current school year) \_\_\_\_\_

IF PRN, IDENTIFY WHEN MEDICATION IS TO BE ADMINISTERED \_\_\_\_\_

***MUST THIS MEDICATION BE ADMINISTERED DURING THE SCHOOL DAY IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL TO***

***ADDRESS THE STUDENT'S MEDICAL CONDITION?*** \_\_\_\_\_ ***SIDE EFFECTS:*** \_\_\_\_\_

\_\_\_\_\_  
***DOCTOR'S SIGNATURE*** PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_

May student self- administer? YES NO
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ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

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 Harvard District #50 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, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD BE PERFORMED BY AN INDIVIDUAL OTHER THAN THE SCHOOL NURSE OR HEALTH AIDE, 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 the School District, it's 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.

***PARENT SIGNATURE*** for PERMISSION TO ADMINISTER MEDICATION \_\_\_\_\_ DATE \_\_\_\_\_