

**Parent and Physician Authorization for Medication Administration**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: 9 10 11 12

**I, as parent/legal guardian of the above mentioned student, do hereby authorize District 208 and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child the lawfully prescribed medication in the manner described below. I agree and acknowledge that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against District 208, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify District 208, 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.**

Parent Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

***All medication, prescription or non-prescription must be in the original pharmacy or manufacturer's container.***

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time of Administration: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Intended effect of the Medication: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Estimated Duration of Drug Therapy: \_\_\_\_\_

Other Medications the child is receiving: \_\_\_\_\_

***Physician Authorization***

Name of Physician (print): \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_