SCHILLER PARK
SCHOOL DISTRICT 81

Dr. Kimberly A. Boryszewski
Superintendent
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MEDICATION AUTHORIZATION FORM

Students Name: _____ Date of Birth: _____ Grade: _____

Address: _____ Phone: _____

The following is to be filled out by the Physician:

Medication: _____ Dosage: _____ Route: _____

Time to be administered: _____ Duration of Administration: _____

Diagnosis: _____

Possible side effects of the medication: _____

Emergency Medication: EPI PENS and RESCUE INHALERS ONLY
MD must initial choice

_____ Student may carry this medication on his/her person
(It is recommended that "back-up" medication be stored in the nurse's office)

_____ Student may self-administer medication. I have instructed the student on the administration of this medication and find that he/she is able to administer this medication independently

Physician's Name (Please Print): _____

Address: _____ Phone: _____

Physicians Signature: _____ Date: _____

Parent/Guardian Authorization

Schiller Park School District 81 and its employees and agents, are hereby authorized to administer to the above named student or to allow the self-administration of the lawfully prescribed medication described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered I waive any claims against the School District and its employees, which might arise out of the administration of said medication. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

_____ _____
Signature of Parent or Legal Guardian Date

Reviewed by School Nurse: _____ Date: _____

CC: ❑ Teacher ❑ PE/Coach ❑ Cafeteria Mgr