SCHOOL DISTRICT 126
ALSIP-HAZELGREEN-OAK LAWN

MEDICATION AUTHORIZATION FORM

NAME: _____ BIRTHDATE_____
SCHOOL: _____ GRADE:_____ TEACHER: _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

NAME OF MEDICATION: _____ DATE:_____
DOSAGE: _____ ROUTE: _____ FREQUENCY: _____
TIME OF ADMINISTRATION: _____ MAY STUDENT SELF-ADMINISTER?: _____
DIAGNOSIS REQUIRING MEDICATION: _____
INTENDED EFFECT OF MEDICATION: _____
POSSIBLE SIDE EFFECTS: _____
OTHER MEDICATIONS STUDENT IS RECEIVING: _____
INITIAL DATE OF MEDICATION: _____ DISCONTINUATION DATE: _____
DATE OF NEXT DOCTOR APPOINTMENT: _____
PHYSICIAN'S SIGNATURE: _____
PHYSICIAN'S NAME PRINTED: _____
ADDRESS: _____ PHONE:_____

PARENT CONSENT:
I HEREBY AUTHORIZE SCHOOL DISTRICT STAFF MEMBERS TO ADMINISTER THE ABOVE NAMED MEDICATION TO MY CHILD DURING SCHOOL HOURS CONSISTENT WITH THE DOSAGE INSTRUCTIONS ABOVE, AND I HEREBY INDEMNIFY AND HOLD HARMLESS ANY SCHOOL DISTRICT STAFF MEMBER AND SCHOOL DISTRICT 126 FROM ANY AND ALL LIABILITY ARISING FROM ACTIONS CONSISTENT WITH THIS FORM. I CAN BE REACHED AT THE FOLLOWING NUMBER(S) IN CASE THERE IS A QUESTION OR PROBLEM.

PARENT/GUARDIAN SIGNATURE: _____
(____)_____OR (_____)_____
(phone number) (phone number)
DATE: _____

SCHOOL NURSE SIGNATURE: _____ DATE: _____