OGLESBY PUBLIC SCHOOLS

MEDICATION AUTHORIZATION FORM

Dear Parent or Guardian, DATE_______________

By signing below, I agree that I am primarily responsible for administering medication to my child. However, I authorize Oglesby Public School District 125, and its employees and agents, on my behalf and in my stead, to administer medication to my child or to allow my child to self-administer medication while under the supervision of the employees and agents of the school district, lawfully prescribed medication in the manner listed below. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so 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 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 incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct.

Student's Name______________________________ Date of Birth_________________ Grade________________

Name of Medication____
(Include brand and generic names)

Please circle Medication to be given: Tablet/Capsule Ointment Liquid Inhalation Injection Rectal

If other please specify___________________________________ Color of Medication____________________

Dosage to be given____________________ Time of Medication administration_____________________________

Side effects (expected or predictable)____

What to do if side effects occur____

Contraindications for the administration of this Medication____

Reason for the administration of this Medication (Student's Diagnosis)___________________________________

Does this student have permission to self-medicate? Please circle: Yes No

If yes, please make sure that this student is capable of using this medication independently, understanding the need for the medication, instructed in the use of this medication, and instructed in the side effects of the medication, and the necessity to report the side effects to school personnel.

Physician's Signature___________________________ Parent Signature_____________________________

Physician's Phone # ____________________________ Parent Phone # ______________________________