LELAND COMMUNITY UNIT SCHOOL DISTRICT #1
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

Student's Name: ____ Birth Date: ___________

Address: ____ Phone: _____________

Parent/Guardian
Name(s):____

AUTHORIZATION FOR THE ADMINISTRATION OF *PRESCRIPTION* MEDICINE
(TO BE COMPLETED BY THE STUDENT'S PHYSICIAN)

Name of medication: ____

Dosage: ____________________ Frequency: ___________________ Time to be given at school: _____

Prescription Date: _________________ Date Ordered: ________________ Discontinuation Date: _____

Diagnosis requiring medication:
____

Intended effect of this medication:
____

Expected side effects:
____

Time interval for re-evaluation: _____________________ Other meds. student receives: ________________

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? ______________

Physician's Signature:**____** Date:___________________

Address:____

Office Phone:________________________ Emergency Phone: _________________________

AUTHORIZATION FOR THE ADMINISTRATION OF *NON-PRESCRIPTION* MEDICINE
(TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN *AND* PHYSICIAN)

The following non-prescription medicine (i.e. Tylenol, Motrin, aspirin/aspirin products, antacids, salves, cough drops, cough medicine, etc.) may be administered to my child/ren at Leland School.

Medicine(s):____

Student name(s):____

Parent Signature:____

Signature of Physician:
____

I am primarily responsible for administering medication to my child/ren, however, if I am unable to do so, I hereby authorize Leland School and its employees and agents to administer, or attempt to administer to my child/ren (or allow my child/ren to self-administer while under the supervision of said district employees) above named lawfully prescribed and non-prescription medication. I acknowledge that it may be necessary for the administration of medications to my child/ren to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when medication is administered, I waive any claims I might have against the Leland 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, 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 of said medicine.

Signature of Parent ____________________________ Date __________