GOREVILLE SCHOOL DIST. #1 MEDICATION AUTHORIZATION FORM

2019-2020

TO BE COMPLETED BY PARENT /GUARDIAN

STUDENT'S NAME: _____ DOB: _____ GRADE: _____

ADDRESS: _____

NAME OF MEDICATION: _____ DOSAGE:_____

Please Check all that apply: You may give my child: _____Ibuprofen _____Tylenol

_____ DO NOT GIVE ANY MEDICATIONS TO MY CHILD

NAME OF DOCTOR & FACILITY: _____

I hereby authorize Goreville Community Unit School District No. 1 and its employees and agents, in my behalf and stead, to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described by a physician. 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 hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damage, causes of action or injuries incurred or resulting from the administration of said medication.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE:____ _____

TO BE COMPLETED BY STUDENT'S PHYSICIAN

NAME OF MEDICATION: _____ DOSAGE: _____TIME: _____

REASON FOR MEDICATION: _____DURATION OF ADMINISTRATION: _____

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? _____ Side effects to be alert to:

_____

DOCTOR'S NAME (PLEASE PRINT)_____

DOCTOR'S SIGNATURE: _____

PHONE NUMBER: _____ DATE: _____

FURTHER REMARKS: _____