GOREVILLE SCHOOL DIST. #1 MEDICATION AUTHORIZATION FORM

2020-2021

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: ____