Community Consolidated School District #46
School Medication Authorization Form

Student's Name ____
Address ____
Telephone Number ____
Birth date ____
School ____
Grade ____
Emergency Telephone Number __________________________________

I, ________________________, parent or guardian of _____________________________ hereby authorize Community Consolidated School District #46, and its employees, in my behalf and stead, to administer to my child lawfully prescribed medication in the manner described below. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, to indemnify and hold harmless the school district and it's employees, either jointly or severally, from and against any and all claims, damages, liability, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

______________________________ ____________________________
Parent's Signature Date

(To be completed by the student's physician)

Name of Medication ________________________ Time__________________
Dosage at School ________________________Daily Dosage _____________
Duration of Administration ____
Type of Disease or Illness ____

Must this medication be administered during the school day in order to allow the child to attend school? Yes ___ No ___

Are there any side effects to the medication? Yes ____ No _____

If yes, please specify ____

_________________________ _______________________
Doctor's Name (Print) Doctor's Signature

Address ____

Telephone Number _________________Emergency Telephone #______________

PLEASE RETURN TO YOUR CHILD'S SCHOOL