AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION AT SCHOOL

Pawnee Community Unit School District #11

Phone (217) 625-2471 Fax (217) 625-2251

The following section is to be completed by the **PHYSICIAN:**

STUDENT'S NAME ___________________________________ **DATE OF BIRTH** ___________________

NAME OF MEDICATION ____

DOSAGE ___________________________________ **ROUTE OF ADMINISTRATION** ___________________

TIME OF ADMINISTRATION AT SCHOOL ____

If the medication is to be given on an "as needed" basis, how soon it can be repeated? : _____________

DIAGNOSIS for which the medication is required to be given at school _______________________________

POSSIBLE SIDE EFFECTS____

Physician's Signature	**Date**
Physician's Name – please print	**Phone**
Address	**Fax**

The following section is to be completed by the **PARENT:**

STUDENT'S NAME ____ ___________ ______________

	Grade	**Date of Birth**

I request that the above named medication be administered to my child as instructed by the physician. I confirm that I am responsible for administering medication to my child. However, in the event that I am unable to do so during school hours, I hereby authorize Pawnee School District #11 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed over the counter medication in the manner described above. I acknowledge that it may be necessary for the administration of said medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed over the counter medication is so administered or attempted to be administered, I waive any claims I might have against the Pawnee School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the Pawnee 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 attempts at administration of medication. I also understand and will comply with the requirements for sending medication to school in the original container from the manufacturer which is properly labeled with my child's name. I understand that it is my responsibility to see that the medication arrives at school in a safe manner. I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

Parent/Guardian Signature	**Date**
Address	**Home Ph / Work Ph/Cell**
Emergency Contact Person	**Phone**