FRANKFORT C.C. SCHOOL DISTRICT 157-C
School Medication Authorization Form

Student's Name: ______________________________ Birth Date: ______________________

Address: ____

Home Phone: ___________________________ Emergency Phone: _____________________

School: ____________________ Grade: ____ Teacher: ______________________________

TO BE COMPLETED BY STUDENT'S PHYSICIAN:

Name of Medication: ____

Dosage: _______________ Frequency: _________________ Route: _____________________

Date of Order: _____________________________________ Time/Given in School: _________

Discontinuation Date: ______________________________ Date of Prescription: __________

Diagnosis requiring medication: ____

Expected side effects, if any: ____

Other medication(s) student is receiving: _______________________________________

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*Allergies: ____

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

_______________________________________ _________________________________

Printed Name of Physician Physician's Signature

___________ ______________________ _________________________________

Date Office Phone Emergency Phone

I confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Frankfort School District 157-C and its employees and agents, in my behalf and stead, to administer or to attempt 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 above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS 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 medication is so administered or attempted to be 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, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

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Parent/Guardian Signature Date