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