HEALTH SERVICES

PERMIT FOR AUTHORIZED PERSONNEL TO ADMINISTER REQUIRED MEDICATIONS DURING SCHOOL HOURS

Child's Name: _____

School: _____ Date of Birth: _____

(TO BE COMPLETED BY PHYSICIAN) Date: _____

This child, _____ is under my medical care for _____ and medication is required during the school day for the purpose of _____ .

Name of Drug	Dosage	Frequency	Time To Be Given at School	Duration	Side Effects

_____
Signature of Physician

_____
Printed Name of Physician

_____
Address

_____
Emergency Telephone Number

APPROVED:

School Nurse

Date

PARENTAL AUTHORIZATION:

I herewith acknowledge 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 West Aurora School District # 129 and its employees and agents, on 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.

_____ _____
Parent(s)/Guardian(s) Signature Date

_____
Address City State Zip Code

_____
Telephone: Home Cell Work