PHYSICIAN AUTHORIZATION FOR MEDICATION AT SCHOOL

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_____ ___ / ___ / ___ _____

Student's Name: (Last, First, Middle) Birthdate Date

School:_____ Grade:_____ Teacher:_____

Medication: _____ Dosage: _____

Time to be administered: _____p.m / a.m.

Intended effect of medication:_____

Expected side effects, if any: _____

Administration instructions:_____

Duration of administration:_____

Other medications student is taking:_____

Asthma medication: The student understands the need for the medication, is capable of using this medication independently and may carry the medication on his/her person:

Yes_____ No _____

_____ _____

Prescriber's Signature **Date Signed**

_____ _____

Prescriber's Emergency Phone # **Prescriber's Address**

Parent authorization for Medication at School:

I authorize authorities of Roxana School District No. 1 and its employees and agents, in my behalf and stead, 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 further acknowledge and agree that when the lawfully prescribed medication is so 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 the against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

_____ _____ _____

Parent's Signature Emergency Phone # Date