Woodridge School District 68

Medication Authorization Form

To be completed by Parent/Legal Guardian

Student Name: ____

School: ___________________________ **Grade:** ________ **Birth Date:** __________________

Phone Number:________________________ **Emergency Number:**________________________

I herby authorize Woodridge School District 68 and its employees and agents, in my behalf and stead to administer to my child lawfully prescribed medication in the manner described below. **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, I waive any claims I might have against the Woodridge School District 68, it employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Woodridge School District 68, 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 of said medication

I hereby grant Woodridge School District 68 permission to contact the physician prescribing the medication for my child when deemed necessary.

Parent Signature: _______________________________________ **Date:** ________________________

To be completed by Physician

Name of Medication: ____

Dosage: ____________________________________ **Concentration:** ____________________________

Frequency: **Daily**________ **PRN**_________ **Time Given:** __________________________________

Route: ____

Type of Disease/Illness: ____

Side effects of medication:____

Physician Signature:____**Date:**_________________________

Address: ____**Phone:**________________________

CD 07/2019