Student Medical Authorization Form

Student Name ___________________________________ Date of Birth _______________

Address ____

Home Phone ___________________________ Emergency Phone ____________________

Name of Drug	Dosage	Frequency	Time to be Given at School	Duration	Side Effects

Signature of Physician ____

Printed Name of Physician ____

Address ____

Office Phone ____________________________ Emergency Phone ______________________

For all parents/guardians:

I hereby 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 (name of School District) 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 an employee or agent of the School District, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that 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 indemnif y the School Districts, 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/Guardian Printed Name ____

Signature ____ Date ___________________