

# Riverton Community Unit School District #14

## SCHOOL MEDICATION AUTHORIZATION FORM FROM THE PHYSICIAN

When it is necessary for a student to have medication administered during the school day, the following directions to the school personnel from the physicians are required:

\_\_\_\_\_ (Name of Student)

\_\_\_\_\_ (Address)

should take \_\_\_\_\_ of \_\_\_\_\_ (Dosage) (Name of Medication)

at \_\_\_\_\_ for \_\_\_\_\_ (Time of Day) (Period of Time)

\_\_\_\_\_ (Possible Side Effects)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ (Physician's Signature)

**From the Parent or Guardian:**

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize RIVERTON SCHOOL DISTRICT #14 and its employees and agents, in 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 OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICE. I further acknowledge and agree that, when the 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 indemnify the School District, its employees and agents, wither jointly or severally, from and against any and all claims, damages, causes or actions or injuries occurred or resulting from the administration or attempts at administration of said medication.

**I give permission for the school nurse/building principal to contact the above physician in regard to any medication concerns.**

\_\_\_\_\_ (Date) \_\_\_\_\_ (Parent or Guardian's Signature)

\_\_\_\_\_ (Address)

\_\_\_\_\_ (Phone Number)

Parents should supply the school with sufficient medication for at least one week. The medication container must be labeled appropriately by the pharmacy or physician with the following:

- A. Name of child
- B. Name of medication
- C. Dosage to be given and intervals.
- D. Time of day to be given
- E. Physician's name
- F. Date of prescription