

PARENT AUTHORIZATION FOR SELF ADMINISTRATION OF MEDICATION

Student’s Name: _____ Birth Date: _____

Address: _____ Grade: 9 10 11 12

I, as parent/legal guardian of the above mentioned student, do hereby authorize District 208 and its employees and agents, in my behalf and stead, to allow my child to self administer the medication in the manner described below. I agree to hold harmless and indemnify District 208, 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 Authorization: _____ Date: _____

Home Phone Number: _____ Work Phone Number: _____

All medication, prescription or non-prescription must be in the original pharmacy or manufacturer’s container.

Name of Medication: _____ Dosage: _____ Route: _____

Time of Administration: _____ Diagnosis: _____

Intended effect of the Medication: _____

Side Effects: _____

Estimated Duration of Drug Therapy: _____

Other Medications the child is receiving: _____

Physician Authorization

Name of Physician (print): _____

Address: _____ Phone number: _____

Physician’s Signature: _____ Date: _____