

SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT NAME: _____

ADDRESS: _____

TELEPHONE: _____

BIRTHDATE: _____

SCHOOL: _____

GRADE: _____

EMERGENCY TELEPHONE NUMBER: _____

I, _____, parent/guardian of _____

hereby authorize Hoover-Schrum School District No. 157, and its employees and agents, in my behalf and stead, to administer to my child (or 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 below. 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 indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and cost expended in defenses thereof, incurred or resulting from the administration of said medication.

Parent/Guardian Signature

Date

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

NAME OF MEDICATION: _____

DOSAGE: _____ TIME: _____

DURATION OF ADMINISTRATION: _____

TYPE OF DISEASE OR ILLNESS: _____

(OVER)

MUST THIS MEDICATION BE ADMINISTERED DURING THE SCHOOL DAY IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL?

___YES ___NO

ARE THERE ANY SIDE EFFECTS TO THE MEDICATION? ___YES ___NO

IF YES, PLEASE SPECIFY: _____

DOCTOR'S NAME (PRINT)

DOCTOR'S SIGNATURE

ADDRESS

PHONE NUMBER

CONSENT FORM FOR EMERGENCY TREATMENT OF INSECT STINGS AND BITES

I, _____, physician of _____,

this _____ day of _____, 20____, hereby acknowledge that he/she is allergic to insect bites. The administration of epinephrine to _____ is necessary after he/she has been stung or bitten to prevent a life threatening situation.

Doctor's Name (Print)

Doctor's Signature

Address

Phone Number

Date

Further Instructional Remarks: _____
