SCHOOL MEDICATION AUTHORIZATION FORM

Student Name _____ Birth date _____

Address _____ Phone _____

School _____ Grade _____ Homeroom _____

Emergency Name and Number_____

I hereby authorize Hillsboro School District #3 and its employees and agents, in my behalf and stead, 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, a 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 hold harmless and indemnify the School District, 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.

_____ _____

Parent's Signature Date

ONLY THE **PHYSICIAN/PRIMARY CARE PROVIDER** MAY COMPLETE THIS PORTION OF THE FORM UNDER THE DOUBLE LINE.

#1. Name of Medication _____

Dosage _____ Time _____

Duration of Administration _____

Type of Disease or Illness _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? _____

Side Effect to be alert to: _____

#2. Name of Medication _____

Dosage _____ Time _____

Duration of Administration _____

Type of Disease or Illness _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? _____

Side Effect to be alert to: _____

_____ _____

(Doctor's Name-Print) **(Doctor's Signature)**

_____ _____

(Address) **(Date)**

_____ _____

(Telephone) (Emergency Number)

FURTHER INSTRUCTIONAL REMARKS/INSTRUCTIONS _____

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