Calhoun CUSD #40

Medication Authorization Form

Nurse Lisa Dolan • Phone: 618-576-2341 • Fax: 618-576-2787

Student's Name_____ Birthdate_____
Last First Middle

Address_____ City_____ Zip_____

Phone_____ Grade_____ Teacher_____

Emergency Contact 1_____ Emergency Contact 2_____

Phone_____ Phone_____

I hereby authorize Calhoun CUSD #40 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), 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.

Name of Medication_____ Dosage_____ Time_____

Duration of Administration_____ Type of Disease or Illness_____

Medical Providers

_____ (Name of Medication) must be administered during the school day in order to allow the child to attend school or to address the student's medical condition.

Side effects to be alert to: _____

_____

Doctor's Name (Print) _____ Date_____

Address_____ Phone_____

Further Instructional Remarks_____

_____

Physician's Signature_____ Date_____
(For Prescription Medication)

Parent Signature_____ Date_____