WINNEBAGO DISTRICT 323
MEDICATION AUTHORIZATION FORM

TO: PARENT OR GUARDIAN

Our school policy states that all prescription and non-prescription medications that are given during school hours must have this form completed prior to the administration of any medication. No medication will be given unless absolutely necessary for the critical health and well-being of the student.

All medication sent to school must be:

1. In original prescription bottle or non-prescription in the original manufacture package
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route and time to be given, name of pharmacy
3. Medication should be brought to school by the parent/guardian or other responsible adult

Please complete this form and return it to the school nurse. Information is kept confidential.

INFORMATION OBTAINED FROM PHYSICIAN:

Student Name: _____ Birth Date: _____

Name of Medication and Dosage: _____

Route and Time: _____

Diagnosis/Reason for Medication: _____

Approval for Self-Administration:
(Field trips or medication required at a time when the nurse if not in the building) _____ (Yes/No)
Self-administration will be under the supervision of voluntary school personnel.

Approval for student to carry emergency medication:
(e.g. inhalers) Recommended for ages 10 and over. _____ (Yes/No)

_____ _____ _____
(Physician Name) (Date) (Phone)

PARENT AUTHORIZATION AND SIGNATURE:

I authorize Winnebago Schools and its employees, on my behalf and stead, to administer or attempt to administer (or allow my child to self-administer while under the supervision of the employees and agents of this school district) to my child this lawfully prescribed medication and any prescribed changes. 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 and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be 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 release, hold harmless, and indemnify the District and its employees from any and all claims, damages, causes of action or injury incurred or resulting from the administration or attempts and administration of said medication.

_____ _____ _____
(Parent/Guardian Signature) (Date) (Phone)