PARIS UNION SCHOOL DISTRICT 95

REQUEST FOR SCHOOL ADMINISTRATION OF MEDICATION
(required to give medication at school)

Student's Name_____ School_____

Age_____ Grade_____
Allergies_____

TO BE COMPLETED BY PHYSICIAN:

Medication
Name/Dosage_____Time_____Route_____

Disease/illness of Student_____

Action of drug_____

Side effects of drug_____

_____

Other Medications Child Is Receiving?

_____
To be given until what date?

_____

_____ _____
Parent Signature Physician Signature or Name

_____ _____
Date Physician Address

_____ _____
District Nurse Initials/Date Physician Phone Number

The above named medication is to be brought to school in a container appropriately labeled by the pharmacy or physician. **Over the counter medications must be in a new unopened bottle or package.**

Please return completed form with medication to school, as well as the completed Parental Authorization for School Administration of Medication form.

PLEASE COMPLETE BOTH SIDES

Parental Authorization for School Administration of Medication

(required to give medication at school)

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so due to medicine being on a regular basis or prescribed at a particular time during the school day, or in the event of a medical emergency, I hereby authorize Paris Union School District No. 95 and its employees and agents, on my behalf and stead, to administer or to attempt 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 above. 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 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 or attempts at administration of said medication.

_____

Student's Name

_____ _____

Parent's Signature Home Phone Cell Phone

_____ _____

Parent's Address Business Phone

_____

Date

Additional Information

_____

_____

_____

PLEASE COMPLETE BOTH SIDES