

**BEMENT COMMUNITY UNIT SCHOOL DISTRICT #5**  
**Fax No. 217-678-4251**  
**SCHOOL MEDICATION AUTHORIZATION FORM**

**TO BE COMPLETED BY PARENT /GUARDIAN:**

STUDENT'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TEACHER: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

I hereby confirm my primary responsibility to administer medication to my child. In the event that I am unable to do so, I hereby authorize Bement Community School District #5 and its employees and agents, in 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 by our physician. 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, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or attempts at administration of said medication. I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication. I also understand that the school may contact the physician if there are problems regarding this medication. (This includes psychiatric medications prescribed to be taken during school hours.)

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:**

Physician's Printed Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Medication \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time Medication is to be administered or under what circumstances: \_\_\_\_\_

Prescription Date: \_\_\_\_\_ Discontinue Date: \_\_\_\_\_

Diagnosis requiring medication: \_\_\_\_\_

Intended effect of this medication: \_\_\_\_\_

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? Please circle: Yes No

Expected Side Effects, if any: \_\_\_\_\_

Other medication student is receiving, if any: \_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTE: MEDICATION MUST BE IN CORRECTLY LABELED PHARMACY CONTAINERS**