

Itasca School District #10 Medication Authorization Form

To Be Completed by Physician or Dentist:

Student Name:	Date of Order:
Diagnosis requiring medication:	
Medication Required (Denote name, exact dosage, & route):	
Time to be given in school:	
Other medications student is taking that may interact with this medication:	
Is student able to self administer this medication? Yes or No	
Is medication needed during school day for critical health & well-being of student? Yes or No	
Physician Signature	

Print Physician Name:	Phone Number:
Address:	
City:	Zip:

To Be Completed by Parent or Legal Guardian:

I request that school personnel give the above medication and/or treatment ordered by the physician as stated above, according to the directions given. *I authorize a representative of the school to exchange information about this medication and/or treatment with the above named health care provider, as needed.* I acknowledge that it may be necessary for medication to be administered to my child by an individual other than a school nurse, and I specifically consent to this. I further acknowledge and agree that, when the lawfully prescribed medication is administered or is self-administered by my child, I waive any claims I might have against 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.

Date
Signature of parent /guardian

No medication will be given, nor dosage changed, unless this form is presented to the School Nurse or Principal. A separate form is required for EACH medication.