Medication Authorization Form

LEXINGTON COMMUNITY UNIT #7 SCHOOLS

Important!

All medication must be in original container and labeled with your student's name.

All medication must be approved by your Physician.

Student's Name ____ Birth Date ___________ Grade ________

TO BE COMPLETED BY PHYSICIAN:

Name of Medication ____ Dosage _______________

Reason to be given ____ Time to be given ______________

Physician's Name (printed) ____

Office phone number ____ Date ________________________

- **For inhaler use only**: I certify that the above name student has been instructed n the use and self-administration of this inhaler. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using the medication independently.

Physician's Signature ____

PARENTAL AUTHORIZATION:

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 or in the event of a medical emergency, I hereby authorize, Lexington Community #7 Schools 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.

Signature of Parent/Guardian ____ Date _______________

STUDENT RELEASE FOR CARRYING INHALER:

1. I have demonstrated the correct use of my inhaler to my Dr. and my school nurse.
2. I agree to never share my inhaler with another person.
3. I agree that if there is not noticeable improvement after 2 puffs from my inhaler, I will notify a teacher or other responsible adult, who will seek further medical intervention.

Student's Signature ____ Date _______________