Itasca School District #10 Medication Authorization Form

To Be Completed by Physician, P.A., Nurse Practitioner, 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:	
For Epi pens or inhalers; will student 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, or to self-administer, 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 separately, 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. Itasca School District, its employees and agents, shall incur no liability, except for willful and wanton misconduct, as the result of any injury arising from the self-administration of medication by the above named student. By signing this document, the parent/guardian indemnify and hold harmless the school district, its employees and agents against any claims, except a claim based on willful and wanton misconduct, arising out of the self-administration of medication by the above named student. Parents or Guardians of the pupil understand that the **permission for the self-administration of any medication is effective for the school year for which it is granted and shall be renewed each subsequent year**, only upon fulfillment of the requirements hereof. Provided these requirements are fulfilled, a pupil with an epi-pen or inhaler may possess and use his or her medication while in school, while at a school sponsored activity, while under the supervision of school personnel or before or after normal school activities such as while in before-school or after-school care or on school-operated property.

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Date Signature of parent /guardian