Geneva Community Unit School District #304

SCHOOL MEDICATION AUTHORIZATION FORM

Only one medication per form

Student's Name: _____ Birth date: _____
School: _____ Grade: _____

I hereby confirm primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Geneva Public Schools and its employees and agents, in my behalf and stead, to administer, or to attempt to administer, to my child, or 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 OR HEALTH AIDE, 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 Geneva School District, its employees and agents, either jointly or severally, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, or attempt at administration, of said medication.

I hereby grant Geneva School District permission to contact the physician prescribing the medication for my child when deemed necessary.

_____ _____

Parent/Guardian Signature **Date**

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN FOR ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATION:

Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition? YES ___ NO ___

Name of medication: _____
Dosage:_____ Frequency:_____Route:_____Time to be given in school:_____
Diagnosis requiring medication:_____
Intended effect of this medication: _____Side Effects: _____
Time interval for re-evaluation:_____
Other medications the student is receiving:_____

For asthma, epinephrine, and diabetic medications only:
Will this student self carry medication? YES ___ NO ___
Will a second set of medication be kept in the health office at school? YES ___ NO ___

_____ _____

Physician's Name—Print **Physician's Name—Signature**
Telephone Number:_____ Date:_____