ROE Alternative Program
of Lake County

MEDICATION AUTHORIZATION FORM

Medications cannot be administered at school without a doctor's written order and a written request from the parent or guardian.

School:_____

Student Name:_____ Birthdate:_____

Parent/Guardian Name:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY <u>THE PHYSICIAN</u>:

Medication (1):_____ Dosage:_____

Time interval to be taken:_____ Duration:_____

Possible side effects:_____

Condition for which medication is being given:_____

Must this medication be administered during the school day in order to allow child to attend school or to address the child=s medical condition?

Q Yes Q No

Medication (2):_____ Dosage:_____

Time interval to be taken:_____ Duration:_____

Possible side effects:_____

Condition for which medication is being given:_____

Must this medication be administered during the school day in order to allow child to attend school or to address the child=s medical condition?

Q Yes Q No

Physician's Signature:_____ Date_____

Physician's Name:_____ Office Phone:_____ FAX:_____

PLEASE PRINT

TO THE PARENT/GUARDIAN:

All medications to be taken at school must be supplied by the parent per SEDOL policy. This request terminates at the end of the physician=s prescribed orders or the end of the current school year B whichever occurs first. SEDOL Nursing may consult with the prescribing physician regarding school medication.

By signing below, I agree 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 SEDOL and its employees and agents, in my behalf, 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 SEDOL), lawfully prescribed medication in the manner described by the physician. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a SEDOL nurse and specifically consent to such practices**, and I agree to indemnify and hold harmless SEDOL and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

I hereby request and grant permission for professional school personnel to administer the above prescribed medication(s) to my child during the school day.

_____

PARENT/GUARDIAN SIGNATURE DATE

CC: **SEDOL Nurse**
Central File
Cumulative Folder
Form #131 (Revised 2/07) sm
KAC (Revised 08/07)