

**REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL**  
Edwardsville Community Unit School District #7

**TO BE COMPLETED BY PHYSICIAN**

**All medications require a new order each year and whenever changes occur.**

Student Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone#: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

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Diagnosis: \_\_\_\_\_

Medication	Dose	Route	Time/Frequency
Special instructions: _____			
Side effects of medication: _____			
Date to Start: _____		Date to Discontinue: _____	

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Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician's name (please print): \_\_\_\_\_  
Physician's address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

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**TO BE COMPLETED BY PARENT/LEGAL GUARDIAN**

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_, hereby authorize the Edwardsville School District and its employees and agents, on my behalf and in my stead, 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 below. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes, of action of injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_