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: _____

Diagnosis: _____

_____	_____	_____	_____
Medication	Dose	Route	Time/Frequency

Special instructions: _____

Side effects of medication: _____

Date to Start: _____ Date to Discontinue:_____

Physician's signature: _____ Date: _____

Physician's name (please print): _____

Physician's address: _____ Office Phone: _____

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 student or to allow my student 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 student 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 student's parent/guardian, or by my student'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 student's parent/guardian, or by my student's physician, physician's assistant, or advanced practice registered nurse.

Parent/Legal Guardian Signature: _____ Date: _____