UNITY

STARTS

WITH

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Ellen Ramsden-Belotti
Director of Special Education

DEPARTMENT OF SPECIAL EDUCATION

Administration Center
1500 Sangamon St.
Crete, Illinois 60417
708-367-8350 PH
708-672-2615 FX

www.cm201u.org

MEDICATION AUTHORIZATION FORM

Date _____

Students Name _____ DOB _____

Teacher/School of attendance _____ Grade _____

Medication to be given during school hours:

Name of Medicine	Dosage	Route	Time

Expiration date of order: _____

Reason for administration of medication (diagnosis): _____

Expected length of treatment: _____

Possible side effects of medication: _____

_____

Physician's signature_____Date_____
Address _____
Phone_____

Parents Authorization

I hereby authorize school personnel to administer the prescribed medication to my child during school hours as prescribed by the above physician. I acknowledge that it may be necessary for the administration of medications to my child be performed by any authorized individual 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 the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, 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.

Parents Signature _____Date _____