

Nippersink District #2

Nippersink Middle School
10006 Main St.
Richmond, IL 60071
815-678-7129 Fax 815-678-7210

Richmond Grade School
5815 Broadway St.
Richmond, IL 60071
815-678-4718 Fax 815-678-2279

Spring Grove Grade School
2018 Main St.
Spring Grove, IL 60081
815-675-2342 Fax 815-675-0030

Medication Authorization

Prescription and Non-Prescription Medication: Physician to complete Part A. Parent/Guardian to complete Part B. Please return form to school.

PART A: ONE MEDICATION PER FORM

Student Name _____ D.O.B. _____

Allergies _____ Grade _____

Medication _____

Dosage _____ Time of Administration _____

Reason for medication _____

Special instructions _____ May Administer/Carry Own Inhaler _____

Watch for these side effects _____ May Administer/Carry Own Epi-pen _____

PHYSICIAN'S SIGNATURE _____

Date: _____

Phone: _____

PART B

To Parents/Guardians: All medication taken at school **must** be brought to the nurse's office. The medication is to be in the original or an appropriately labeled container by the pharmacy, physician, or manufacturer, with pertinent information such as child's name, name of medication, physician name (if applicable), dose, and time of administration.

I hereby request and grant permission for **District #2 School Personnel** to dispense medication to my daughter/son, _____, according to (Physician's Name) _____, instructions above. I further waive any claims against the **School District**, its employees, and agents arising out of the administration of said medication, and agree to hold harmless and indemnify the **School District**, its employees and agents; either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the administration of medication. If applicable, I give permission for my child to administer their own asthma/allergy medication.

PARENT/GUARDIAN SIGNATURE _____

Date _____