Canton Union School District #66
School Medication Authorization Form

Student's Name _____ Birthday_____

Address _____ Home Phone_____

School _____ Teacher_____

Emergency Phone_____

To be completed by student's physician (Prescription) or parent/guardian (Nonprescription):

Name of Medication _____

Dosage _____ Frequency _____ Time to be given at school _____

Date of Prescription _____ Date of Order _____

Discontinuation Date _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? No☐ Yes☐

Expected side effects, if any: _____

_____

Other medication student is receiving _____

_____

_____ _____ _____

Physician's Name (Print) Physician's Name (Signature) Date of Form

Parental Authorization

I herewith acknowledge 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 Canton School District and its employees and agents, on behalf and stead, 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 the School District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, 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 an and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____ _____ _____ _____

Parent's Signature Address Home Phone Business or cell Date

Additional Information: _____

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