Paxton-Buckley-Loda CUSD #10 Students
School Medication Authorization Form

To be completed by the student's parent(s)/guardian(s). A new form must be completed each school year. File the completed authorization form in the School's Medication Administration Binder.

Student's Name: _____ Date of Birth: _____

Allergies: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

PRESCRIPTION MEDICATIONS: To be completed by the student's physician, physician assistant, or nurse practitioner:

Provider's Name (Please Print): _____

Office Address: _____ Office Phone: _____

Medication Name (Please Print): _____

Dosage: _____ Prescription Date: _____ Discontinuation Date: _____

Time to be Administered: _____ Route to be Administered: _____

Diagnosis: _____ Possible Side Effects: _____

Other Medications: _____

Is it necessary for this medication to be administered during the school day? YES NO

May Student self-administer medication under supervision Health Services personnel or designate? YES NO

PROVIDER'S SIGNATURE _____ **DATE** _____

OVER THE COUNTER MEDICATIONS: To be completed by parent/guardian:

Medication Name (Please Print): _____

Dosage: _____ Purpose: _____ Time to be Administered: _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

For all Parents/Guardians: By signing below, I agree 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 the School District and its employees, agents, and affiliates, on my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees, agents, and affiliates 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 waive any claims I might have against the School District, its employees, agents, and affiliates, including Gibson Area Hospital, arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees, agents, and affiliates, including Gibson Area Hospital, 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. Both Parents/Guardians should sign if available.

Parent/Guardian signature _____ Date _____

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER LABELED WITH THE STUDENT'S NAME, NAME OF MEDICATION, DIRECTIONS FOR USE, AND DATE.