KILLDEER PUBLIC SCHOOL
PRESCRIPTION AND AUTHORIZATION
FOR
MEDICATION ADMINISTRATION

When it is determined by the physician and parent that medication must be taken during the school hours this form is to be completed.

Student:_____ School: _____ School Year: _____

Date: _____ Responsible Staff: _____

Allergies:_____

Medication:_____ Dose: _____

Time/Frequency: _____ Continue Until: _____

Reason for Medication: _____

Special Instructions: _____

Possible Side Effects on Learning and Physical Functioning: _____

_____

Date: _____ Physician's Name: _____

Phone: _____ Address: _____

I request this medication be given to my child in the manner specified above. I give permission to school personnel to administer the medication. I understand that the administration of medication will not necessarily be done by a nurse. I will notify school immediately if my child's health status changes, or there is a change or cancellation of this medication.
In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the administration of medications to the above named student from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of the above described medication.

Date:_____ Parent/Guardian: _____

Phone: _____ (W) _____ Address: _____