7.270-E

RIDGEWOOD HIGH SCHOOL DISTRICT 234
SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME: _____ GRADE: ____ BIRTHDATE:_____

ADDRESS: _____ PHONE:_____

EMERGENCY CONTACT NAME AND PHONE NUMBER: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

I _____ parent/guardian of _____ am primarily responsible for administering medication to my child. However, I hereby authorize Ridgewood High School District 234, and its employees and agents, on my behalf and in my stead, to administer to my child lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage is changed. I understand that it is the responsibility of the student to report to the health office at the scheduled time to receive the medication.

I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the school district, its employees and agents, arising out of that administration of said medication. In addition, I agree to indemnify and hold harmless the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication, except a claim based on willful or wanton conduct.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis:_____Name of Medication:_____

Dosage:_____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____ _____

Phone Number of Physician Signature of Physician Date

_____ _____

Address of Physician Print Name of Physician Date