School District 129
WEST AURORA • NORTH AURORA • MONTGOMERY • SUGAR GROVE

PERMIT TO ADMINISTER MEDICATION

A Future of Excellence
VISION 129

Child's Name: _____

School: _____ Date of Birth: _____

TO BE COMPLETED BY PHYSICIAN: Date: _____

This child, _____ is under my medical care for _____ and medication is required during the school day for the purpose of _____ .

Name of Drug	Dosage	Frequency	Time To Be Given at School	Duration	Side Effects

Signature of Physician

Printed Name of Physician

Address

Emergency Telephone Number

APPROVED:
School Nurse
Date

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 West Aurora School District 129 and its employees and agents, on my 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 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 District 129, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify District 129, its employees and agents, 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.

Parent(s)/Guardian(s) Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Cell _____ Work _____