AUTHORIZATION FOR ADMINISTRATION OF MEDICATION
NEW BERLIN,CUSD #16

New Berlin Elementary (217) 488-6054 fax : (217) 488-6039

NB Jr. High (217) 488-6011 fax: (217) 488-3107

NB High School (217) 488-6012 fax: (217)488-3207

The following section is to be completed by the **PHYSICIAN**:

STUDENT'S NAME _____ _____ DATE OF BIRTH _____

NAME OF MEDICATION _____

DOSAGE _____ ROUTE OF ADMINISTRATION _____

TIME OF ADMINISTRATION AT SCHOOL _____ **Discontinuation Date**:_____

If the medication is to be given on an "as needed" basis, how soon it can be repeated? : _____

DIAGNOSIS for which the medication is required to be given at school _____

POSSIBLE SIDE EFFECTS_____

Start Date of Prescription _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name – please print Phone

_____ _____
Address Fax

The following section is to be completed by the **PARENT**:

STUDENT'S NAME _____ _____ _____ _____
Grade **Date of Birth**

I request that the above named medication be administered to my child as instructed by the physician, in accordance with the guidelines for the administration of medication at CUSD #16. I confirm that I am responsible for administering medication to my child. However, in the event that I am unable to do so during school hours, I hereby authorize New Berlin School District #16 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child 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 New Berlin School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the New Berlin School District, 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 medication. I also understand and will comply with the requirements for sending medication to school in the original container from the manufacturer which is properly labeled with my child's name. I understand that it is my responsibility to see that the medication arrives at school in a safe manner. I give my permission for the school to contact the physician by telephone, fax, or in writing when necessary in regards to the medication.

_____ _____
Parent/Guardian Signature Date

_____ _____/_____
Address Home Phone Work Ph/Cell

_____ _____
Emergency Contact Person Phone