Evergreen School District 124
(708) 423- 0950 ex. 2262 or 2260
FAX: (708) 229-8406 (CMS)

MEDICATION AUTHORIZATION FORM

PHYSICIAN'S ORDER

Student's Name: _____ Date of Birth: _____ Grade: _____

Address: _____Telephone:_____School:_____

Medication: _____Diagnosis:_____Dosage:_____ Route: _____

Purpose of Medication: _____

Specific Time/Instructions: _____

Possible Side Effects: _____

Other medications prescribed for this student: _____

Possible drug interactions: _____

Physician's Name (Please print): _____

Address: _____ Telephone: _____

Physician's Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

Evergreen Park School District 124 and its employees and agents, are hereby authorized to administer to the above named student or to allow the self-administration of the lawfully prescribed medication described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered I waive any claims against the school district and its agents/or employees, which might arise out of the 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, except for willful and wanton conduct incurred or resulting from the administration of said medication.

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ Date: _____