GAVIN DISTRICT #37 MEDICATION AUTHORIZATION

Student's Name	Birthdate	Grade	Teacher

To be Completed by Authorizing Physician

Only those medications that is absolutely necessary for the critical health and well being of the student will be administered during school hours. I hereby authorize employees of Gavin School District #37 to act on my behalf in administering the following medication during school hours.

Medication as used in this document will refer to both prescription and non-prescription drugs

Medication_____Dosage_____

Time of Administration_____If PRN state time between doses_____

Start date_____Daily_____Temporary_____Ending date_____

Diagnosis_____

Medication Side-Effects_____

Other medications this child receives_____

Physician's Printed Name_____Signature_____

Physician's Address_____Phone #_____

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To be Completed by Parent/Guardian

I have read the school policy concerning medication administration during the school day. I understand that failure to follow the regulations will result in the school district being unable to honor my request for medication to be administered to my child.

I give permission for my child_____to receive the above named medication as prescribed. I understand that my signature on this form constitutes a waiver by me to the school district, it's Board, officers, and other personnel as to any claim, suit, damages it may be called on to pay or defend in connection therewith. I also understand that my signature on this form denotes permission for the school health official and prescribing physician to confer regarding the administration and monitoring of medication.

Parent/Guardian Signature_____Date_____
Daytime phone #_____

All medications must be transported to school by parent or guardian unless other arrangements are made with the school nurse, Principal, or Principal's designee prior to transport.