North Shore School District 112 Highland Park, Illinois At-School Medication Authorization Form

Child's Name	School/Grade/Teacher				
Address:	DC			DOB:	
that I am unable to do so or in the behalf, to administer or attempt employees and agents of NSSD of medications to my child to be I agree to indemnify and hold ha and wanton conduct, arising out	to administer to my 112), lawfully prest performed by an intermless NSSD 112 of the administration the school districtions at the school of	al emergency, I here y child (or to allow m scribed medication.) Individual other than and its employees ar on or the child's self staff members to dis	by authorize NSS ny child to self- a I acknowledge the the school nurse and agents against administration of sclose my child's	administer, while under the lat it may be necessary for the and specifically consent to any claims, except a claim of medication. It protected health informations	and agents, in my supervision of the he administration such practices, and based on willful
Date	F	Parent/Guardian S	Signature	Phone Number	
	Par	ent / Guardian Pi	rinted Name	_	
Physician Section:					
Name of Medication:			Dose:		
Administration instruction	ns / schedule:				
Diagnosis requiring this n	nedication:				
Prescription date:		Order date:		Date to discontinue:	
Anticipated result:					
Possible adverse effects:					
Time interval for re-evalu	ation:				
Other current prescribed i	nedication stud	ent is taking:			
Physician's Signature					
Print Physician'	s Name:				
Address:					
Phone Number:					