

**RIDGEVIEW SCHOOLS**  
**SCHOOL MEDICATION AUTHORIZATION FORM**

STUDENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_

EMERGENCY PHONE NO. \_\_\_\_\_

*To be completed by the student's physician or parent:*

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

DURATION OF ADMINISTRATION \_\_\_\_\_

TYPE OF ILLNESS OR DISEASE \_\_\_\_\_

MUST THIS MEDICATION BE ADMINISTERED DURING THE SCHOOL DAY IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL OR TO ADDRESS THE STUDENT'S MEDICAL CONDITION? \_\_\_\_\_

POSSIBLE SIDE AFFECTS TO BE ALERTED TO: \_\_\_\_\_

\_\_\_\_\_  
(DOCTOR'S NAME – PRINT) (DATE)

\_\_\_\_\_  
(ADDRESS) (PHONE)

FURTHER INSTRUCTION REMARKS: \_\_\_\_\_

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Ridgeview School District 19 and its employees and agents, in 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 School District), lawfully prescribed medication in the manner described above. 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 School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or separately, 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. I understand that my child is responsible for going to the office or other designated place at the appropriate time for the medication and that the school may contact the physician if there are problems regarding this medication.

\_\_\_\_\_  
(Parent Signature) (Date)

The Schedule for medication described above makes it impossible to provide the required doses outside the school day hours.

\_\_\_\_\_  
(Physician's signature) (Date)

NOTE: MEDICATION MUST BE IN CORRECTLY LABELED PHARMACY CONTAINERS.  
INHALERS MUST HAVE LABEL ATTACHED TO INHALER OR THE BOX.