



Lake Forest School District 67  
**School Medication Authorization Form**  
**(Prescription and Non-Prescription)**

Building	Phone#	Fax#
Cherokee School	234-3805	615-4467
Everett School	234-5713	615-4466
Sheridan School	234-1160	615-4479
Deer Path Middle School East	615-4470	615-4464
Deer Path Middle School West	604-7400	234-2389

Lake Forest School District 67  
**School Medication Authorization Form**  
 To be completed by the student's parent or guardian

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_  
Student's Name

born on \_\_\_\_\_, herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Lake Forest School District 67 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child this lawfully prescribed medication. 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 medicine 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 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 said medication.

NOTE: The parent or guardian is responsible for bringing and removing all prescription and non-prescription medication in its original labeled pharmacy container. Non-prescription medication must be in the original labeled container as dispensed or the manufacturer's labeled container.

\_\_\_\_\_  
 Parent's Signature

\_\_\_\_\_  
 Home Phone

\_\_\_\_\_  
 Parent's Address

\_\_\_\_\_  
 Business Phone

\_\_\_\_\_  
 Fax Number

\_\_\_\_\_  
 Cell Phone Number

Name of Medication \_\_\_\_\_ Date \_\_\_\_\_



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**School Medication Authorization Form**

**To be Completed by Student's Physician**

\_\_\_\_\_  
 Student's Name (Last)                      (First)                      Birth Date                      Diagnosis                      Date

\_\_\_\_\_  
 Medication                      Route                      Dosage                      Time to be administered

\_\_\_\_\_  
 Intended effect of this Medication                      Expected side effects, if any

Other medications student is taking:

\_\_\_\_\_

Administration instructions:

\_\_\_\_\_

\_\_\_\_\_

Discontinue/Re-Evaluate/Follow-up Date (circle one): \_\_\_\_\_

\_\_\_\_\_  
 Prescriber's Signature

\_\_\_\_\_  
 Date Signed

\_\_\_\_\_  
 Prescriber's Name (Please Print)

\_\_\_\_\_  
 Prescriber's Phone

\_\_\_\_\_  
 Prescriber's Address