FENWICK HIGH SCHOOL
Authorization for Medication to be taken during School hours or at School Related Activities

The following section is to be completed by the PARENT/GUARDIAN:

Student's Name______________________________ ____ __________
Last First YR Birthday

______________________________ (___)__________
Physician's Name Address Telephone

I request that my child be assisted in taking the medication(s) described below at school by authorized persons or permitted to self-medicate her/himself as also authorized by me and my physician(see below). The school and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising out of the administration or attempts at administration of said medication or from the self-administration of medication by the above named student. I indemnify and hold harmless the school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or attempts at administration of said medication or from the self-administration of medication by the student.

________ ______________ (___)________ (___)________ (___)________
Date Parent/Guardian Signature Home Phone Work Phone Emergency

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The following is to be completed by the PHYSICIAN:

____
Diagnosis for which medication is given.

____
Name of Medication Form Dosage

If the medication is to be given DAILY, at what time?______________________________

If the medication is to be given"WHEN NEEDED," describe indications:______________________________

____

Is child authorized to self-medicate her/himself?______________________________

Does the child understand the need for the medication and the necessity to report to school personnel any unusual side effects?______________________________

____
Intended effect of the medication List significant side effects

____
Other medication child is taking

Other information:______________________________

____

Date:____________ ______________________________ (___)________
Physician's signature Emergency Number