FENWICK HIGH SCHOOL
Authorization of Medication
Medication to be taken during school hours or at school related activities -Fenwick's Fax: 708-386-4323

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, attempts at administration of said medication, or self-administration of medication by the above named student. I agree to indemnify and hold harmless Fenwick 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

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 the 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 effect? _____

Intended effect of the medication: _____

List significant side effects: _____

Other medication child is taking: _____

Other information: _____

_____

Date: _____ _____ (____)_____
Physician's Signature Emergency Number

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