MAINE TOWNSHIP HIGH SCHOOL
Authorization and Permission for Administration of Medication
(All items must be completed in detail by the physician)

ID# _____

Student's Name _____ Date of Birth _____

Name of Medication _____ Date of Prescription _____

Diagnosis _____ Discontinuation Date _____

Dosage: _____ Route: _____ Frequency and Time of Administration _____

Intended effect of medication: _____

Possible Side Effects: _____

Other medications the student is receiving: _____

Time interval for re-evaluation: _____

Physician Authorization for Self-Administration of Asthma Medication or Epinephrine Auto-Injector *(please circle)*

The student is capable and responsible for carrying and self-administering above named asthma medication. Yes No

The student is capable and responsible for carrying and self-administering above named epi auto-injector. Yes No

LICENSED PRESCRIBER:

Prescriber Name _____ Prescriber Phone/Emergency # _____
(printed)

_____ _____
(Signature and Stamp) (Date of Signature and Order)

Parental/Guardian Authorization:
I hereby authorize Maine Township High School and its employees to administer to my child, lawfully prescribed medication in the manner decribed above. I further acknowledge and agree to waive any claims I might have against District 207 and its employees arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify District 207 and its employees from and against all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

Parent/Guardian Name _____ _____
(Please print) (Signature) (Date)

Emergency Phone # _____

Parent/Guardian Agreement Authorizing Self-Administration of Asthma medication or Epinephrine Auto-Injector
I agree with the doctor statement above to authorize my child to carry and self-administer the above named medication.
I therefore agree to indemnify and hold harmless the School District and its employees from any claim, liability, loss or expense, including reasonable attorneys' fees, suffered by any of the foregoing indemnities and arising out of a claim related directly or indirectly to my son/daughter's self administration of the above reference medication of and brought by me, any other parent/guardian of my student or another student, or by or on behalf of my student or another student.

Parent/Guardian Name _____ _____
(Please print) (Signature) (Date)