

**SILVIS SCHOOL DISTRICT #34  
MEDICATION AUTHORIZATION FORM**

When administering medication at school the following guidelines must be followed. Your permission, along with the prescriber's permission, must be on file in the health office before any prescription or over the counter medication will be administered.

The following is required:

1. Labeled bottle from the pharmacy
2. Name of medication being administered
3. Dosage
4. Time to be administered
5. Route of administration

Student's name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication and Dosage: \_\_\_\_\_

Directions for administration: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Signature of physician, physician's assistant, or advanced practice R.N

**Student's parent or Guardian must complete this section:**

I hereby request and grant permission for Silvis school District #34 and it's personnel to dispense medication or administer prescribed treatment to my son/daughter, \_\_\_\_\_ according to \_\_\_\_\_ (Physicians name) instructions above. I further release and waive any claims against the school district, it's employees and agents arising out of the administration of said medication or treatments and agree to hold harmless and identify the school district, it's employees and agents either jointly or severally from and against any and all liability, claims, demands, damages, or causes of action or injuries, cost, and expenses, including attorney's fees, resulting from or arising out of the administration of medication or treatments to my son/daughter by school personnel.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

**This form is effective for one school year**