REQUEST FOR THE ADMINISTRATION OF MEDICINE
MEDICATIONS CANNOT BE ADMINISTERED AT SCHOOL WITHOUT A DOCTORS WRITTEN ORDER AND A WRITTEN REQUEST FROM THE PARENT/GUARDIAN

Name of Student _____Date of Birth _____

Address _____Emergency Phone _____

School_____ Grade _____

Part I – Physician's Statement

Name/type of medication_____
Dosage/amount to be given _____
Route of administration _____
Frequency and time of administration _____
Duration (week, month, indefinite, etc.) _____
Diagnosis, Intended Effect and Anticipated Reaction to medication (Symptoms, side effects, etc.)

_____
_____
_____

Other medication child is receiving _____
Other requirements _____
Must this medication be administered during the school day in order to allow the student to attend school? _____

_____ _____
Physician's Signature Date signed

_____ (____)_____
Address Telephone

Part II B Parent's/Guardian's Request/Approval

I hereby request and grant permission for Lake Villa School District #41 school personnel to administer _____ or supervise the self-administration of _____ medication to my daughter/son _____, according to the above instructions. I understand that this administration or supervision may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I further waive any claims against District #41, members of the Board of Education, its employees, and agents arising out of the administration of said medication and agree to hold harmless and indemnify the District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims demands, damages, or causes of action or injuries, costs and expenses, including attorney's fees, resulting from or arising out of the administration of medication.

_____ (___)_____ _____
Signed Telephone Date

March, 2007