Brook Forest School
60 Regent Drive
Oak Brook, IL 60523
630-325-6888 Office

Butler Jr. High School
2801 York Road
Oak Brook, IL 60523
630-573-2887 Office

SCHOOL MEDICATION AUTHORIZATION FORM

Student Name:_____Date of Birth:_____

Address:_____

Home Phone:_____ Emergency Phone:_____

School:_____ Grade:_____ Teacher:_____

To be completed by physician:

Name of Medication:	
Dosage:	Date of prescription:
Frequency:	Date of order:
Time to be given at school:	Discontinuation date:
Diagnosis requiring medication:	
Intended effect of this medication:	
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition:	
Expected side effects, if any:	
Time interval for re-evaluation:	
Other medications student is receiving:	
Physician Signature:	
Physician Name (please print):	
Address:	
Office Phone:	
Emergency Phone:	
Date:	

I confirm that I am primarily responsible for administering medication to my child. In the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Butler School District 53 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices.** I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Signature:_____

Parent/Guardian Name (please print):_____

Date:_____

Student signature required if the medication is for asthma and is to be self-administered by the student.

Student Signature:_____

Date:_____

Rev: December 2023