# CRETE-MONEE
SCHOOL DISTRICT 201-U

*Unity Starts With "U"*

690 West Exchange Street
Crete, IL 60417
P: 708-367-8300
www.cm201u.org

Date: ___________________________________________________________________

Student Name: ____________________________________ DOB ___________________

Teacher/School of Attendance _________________________ Grade _________________

Medication to be given during school hours

| Name of Medication | Dosage | Route | Time |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Expiration date of order: ___________________________________________________

Reason of administration of medication (diagnosis): ___________________________________

Expected length of treatment: _____________________________________________________

Possible side effects of medication: _______________________________________________

_________________________________________________________________________

Physician's signature _________________________________ Date: ___________________

Address ____________________________________________________________________

Phone _____________________________________________________________________

**Parents Authorization**

I hereby authorize school personnel to administer the prescribed medication to my child during school hours as prescribed by the above physician. I acknowledge that it may be necessary for the administration of medications to my child be performed by any authorized individual 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's Signature __________________________ Date __________________________