# DISTRICT 125 MEDICATION RELEASE FORM

## 1. ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER TO BE ADMINISTERED.

### 2. PARENT REQUEST

As the parent/guardian of: ______________________________

Date of Birth: __________

Name of Physician: ______________________________

Phone: ______________________

I request that medication be administered to my child in accordance with my physician's instructions as indicated on the original prescription container.
It is understood that District 125 is not obligated to administer medication to my child. I agree on behalf of myself, my child, and any other parent, or guardian of my child to hold the District and its employees harmless from, and indemnify and defend the District and its employees against, every claim, demand or liability for any injury or damage whatsoever, arising from the District's administration of medication to my child.

Signature: ______________________________ Date: ____________________

### 3. PHYSICIAN'S INSTRUCTIONS

☐ Condition for which the drug is to be given:

______________________________

☐ Medication:

______________________________

☐ Time for medication:

______________________________

☐ Dosage and route of administration:

______________________________

☐ Possible side effects:

______________________________

The above medication cannot be scheduled for other than during school hours and may be administered by medically untrained school personnel.

Physician's Signature: ______________________________

Phone Number: ____________________

Date: ____________________ Physician's Address: ____________________

Medication to be continued as above until ____________________

Physician's orders must be renewed annually