AUTHORIZATION TO ADMINISTER MEDICATION

I hereby authorize First Baptist Academy and its employees and agents, on my behalf and stead, to administer lawfully prescribed and/or non-prescription medication (as requested by the parent in writing) to my child. I acknowledge that it may be necessary for the administration of medication to be performed by an individual ather than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when medication is administered, I waive any claims I might have against First Baptist Academy, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify First Baptist Academy, 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 of or attempt to administer medication.

STUDENT NAME LAST | FIRST | MI

STUDENT DATE OF BIRTH MM | DD | YYYY

PARENT/GUARDIAN SIGNATURE

DATE MM / DD / YY

SPECIAL INSTRUCTIONS/INFORMATION:

PARENT MUST SIGN BELOW IN THE PRESENCE OF NOTARY

_____ PARENT / GUARDIAN SIGNATURE

____ / ____ / ____ DATE

State of Illinois

County of _____.

Signed (or subscribed or attested) before me on

_____ *(date)* by _____ *(name of person)*.

_____ SIGNATURE OF NOTARY PUBLIC

SEAL

PHYSICIAN'S ORDER FOR MEDICATION TO BE ADMINISTERED AT SCHOOL

STUDENT NAME	LAST	FIRST	MI
STUDENT DATE OF BIRTH	MM DD YYYY		
DIAGNOSIS			
MEDICATION TO BE ADMINISTERED			
DOSAGE		TIME(S) TO BE ADMINISTERED	
POSSIBLE SIDE EFFECTS			
DURATION OF TIME MEDICATION IS TO BE USED			

SPECIAL INSTRUCTIONS:

COMPLETE THIS SECTION IF STUDENT IS USING A SELF-ADMINISTERED INHALER

I certify that _____ *(student's full name)* has been instructed in the use and self-administration of _____ *(medication)*. He/She understands the need for the medication and the necessity to report to school personnel any effects. He/She is capable of using this medication independently.

_____ _____

ADDRESS PHONE

_____ _____

SIGNATURE OF PHYSICIAN DATE

_____

NAME OF PHYSICIAN (PRINT)