MEDICATION DISPENSING AUTHORIZATION
CASS SCHOOL DISTRICT 63

Important: This MDA form must be completed and signed by the parent (front) and physician (back) for each medication dispensed at school.

Student's Name _____ Date of Birth _____

Address _____ Phone _____

School _____ Grade _____ Teacher _____

In case of emergency, please contact:

Name _____ Phone _____

Name _____ Phone _____

I _____, (please choose one: Parent ____ Legal Guardian ____ or Primary Caregiver ____) of the student named above hereby authorize Cass School District 63 and its employees and agents, in my behalf and stead, to administer to my child lawfully prescribed medication in the manner described below. 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 when necessary. I further acknowledge and agree that, when the lawfully prescribed medication is administered, I waive any claims I might have against the Cass School District 63, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Cass School District 63, 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 said medication.

I hereby grant the appropriate staff at Cass School District 63 permission to contact the physician prescribing the medication for my child when deemed necessary. I further understand the following:

1. Medication is brought to the school in a pharmaceutical container, marked with the child's name, medication and pertinent information.
2. At the end of the school year, I will pick up any unused medication. If medication is not picked up as requested, medication will be appropriately disposed of by school staff.
3. The parent must report immediately any changes in prescription or dosage. New permission forms must be obtained for each change.
4. Parents will be notified whenever a PRN ("as needed") medication is given to the child.

Parent Signature _____ Date _____

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TO BE COMPLETED BY THE PHYSICIAN

(or attach similar written information on the physician's letterhead and signed by the physician)

Name of Medication _____

Duration of Medication Administration ____ Through School Year ____ Other (please specify) _____

Dosage: ____ Daily OR ____ PRN (as needed) Route _____ Time(s) of Day _____

Type of Disease or Illness _____

Possible Side Effects _____

Possible Contraindications _____

Storage Instructions _____

The parent and child have been advised of the proper use of this medication and the risks associated with misuse of the medication. If applicable, the student is capable of appropriately self-administering the medication as instructed, and I have no knowledge of or reason to believe the student would misuse or otherwise abuse the medication..

Physician Name _____ Phone _____

Physician Signature _____ Date _____