WOODLAWN
UNIT SCHOOL DISTRICT #209

300 NORTH CENTRAL LANE
WOODLAWN, ILLINOIS 62898
PH: 618.735.2631 FAX: 618.735.2032
WWW.WOODLAWNSCHOOLS.ORG

Student Name: ______________________________ **Date of Birth:** ___________ **Grade:** _____

MEDICATION ALLERGIES: ____

Parental Authorization:
I, the parent of ______________________________, a student at Woodlawn Unit School District #209, hereby acknowledge that I am primarily responsible for administering medication to my child. However, during school hours when I am unable to administer or in the event of an emergency, I hereby authorize Woodlawn Unit School District #209 and its employees, on my behalf to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the school district), the following named prescription medication, non-prescription medication or over-the-counter medication following manufacturer's guidelines or prescription medication as ordered by the physician.

I acknowledge that prescription medication, non-prescription, or over-the-counter medication will be administered by or under the supervision of the school nurse, or administrative staff, and specifically consent to such practices. I further acknowledge and agree that when the medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees, and School Board/Administration arising of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees, and School Board/Administration, 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: ____

Phone #: ____

Physician Authorization: **Tylenol 500mg. 1 tab po every 4-6 hrs. PRN**
OR
Ibuprofen 200 mg. 1 or 2 tabs. po every 6-8 hrs. PRN

Diagnosis: General aches and pains

Intended effect of this medication: Pain relief and to allow student to remain at school.

Expected side effects, if any: ____

Other medications student is taking: ____

Administration instructions: ____

___________________	_________________________	___________________	_____________________
Prescriber's Name	**Prescriber's Signature**	**Date**	**Prescriber's Phone #**

PLEASE RETURN OR FAX TO 618.735.2288