

**MOUNT PROSPECT PUBLIC SCHOOLS
District 57**

PHYSICIAN'S SCHOOL MEDICATION REQUEST

Student _____ Birth date _____

Medication _____

Dosage _____

Time of day _____

Condition prescribed for _____

Possible side effects _____

Date

Physician's Signature
Required

Physician's Telephone

PARENT'S SCHOOL MEDICATION REQUEST

I request school personnel to administer the medication prescribed above for my child. It is understood that the school district is administering medicine to my child gratuitously and in reliance on my request and the assurance of the physician that the prescribed medication is safe for my child. Accordingly, I hereby release the school district, its Board, officers and other personnel from any and all liability as to injuries or ill-effects of any kind which may be caused thereby, and I further indemnify and agree to defend the school district, its Board, officers, and other personnel as to any claim, suit or damages it may be called on to pay or defend, in connection therewith.

Parent's Signature

Date