



**Elementary/Middle School Office**

188 West Butterfield Road  
Elmhurst, Illinois 60126  
(630) 833-4717  
[www.timothychristian.com](http://www.timothychristian.com)

**Authorization for Administration of Medication at School**

**Parent Permission**

Date \_\_\_\_\_

Student Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Medication \_\_\_\_\_

Dose \_\_\_\_\_

Time \_\_\_\_\_

Subject to doctor's approval, I request that my child be allowed to self-administer the medication  Yes  No

Subject to doctor's approval, I request that authorized school personnel administer the medication  Yes  No

*I hereby request that the above medication be administered at school during school hours.*

Parent/Guardian Signature \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

With regards to self-administration of medications, I acknowledge that the school district, its employees and agents incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by my child.

In addition, I indemnify and hold harmless the school, its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Note: In our effort to ensure the safety of all students, any student in possession of any medication, pills or other drug look-alike substances without proper authorization at school will be subject to suspension. **All** medication must be registered with the elementary/middle school office.