MEDICATION ADMINISTRATION AUTHORIZATION FORM

Student's Name _____ DOB _____

Teacher/Advisor _____School _____Grade _____

Name of Medication _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Diagnosis/Condition _____

Dose, Route other Administration Instructions _____

Frequency & Time(s) to be given at school _____

Dates to be given _____20__/20__ school year or _____

If an AM dose is given at home and is omitted, a dose of _____mg may be given at school after omission is verified by a parent/guardian. School dose may then be given _____ hours later.

Special Side Effects, Adverse Reactions or Contraindications _____

_____

Additional information_____

Licensed Prescriber Signature_____ Date_____

Licensed Prescriber Telephone Number _____

PARENT/GUARDIAN AUTHORIZATION

PLEASE LIST ALL MEDICATION THE CHILD IS TAKING AT HOME (Prescription and over the counter medications) if not a violation of confidentiality

1._____ 2. _____

3. _____4._____

I hereby authorize the designated staff person or school nurse to administer the above medication as directed. In consideration for this service, I further agree that I will not hold liable, and will otherwise save harmless, the District and/or any department or employee thereof for death or injury resulting from administration or assistance in the administration of the medication described above. I understand that (a) not more than one month of prescribed medicine may be stored in school, (b) medication will be delivered directly to the School Nurse, Principal, Assistant Principal, or Principal's designated staff member by the parent or guardian, if possible, and (c) the medication will be delivered in a container properly labeled with the student's name, the physician's name, the date of original prescription, name and strength of medication and directions for taking by the student.

Printed Name of parent/guardian _____

Signature of parent/guardian_____ Date_____

Yes No I give my permission for release/exchange of pertinent information by telephone, mail or electronic exchange including fax or e-mail between the school nurse and the physician's office regarding the above medication.

Yes No I give my permission for other school personnel to be notified of the medication and any adverse effects.

Signature of parent/guardian_____ Date_____

Adopted: May 12, 2021
Reviewed: April 20, 2021