Olympia Community Unit School District # 16
School Medication Authorization Form

When a student must receive **prescription or non-prescription medication (ie tylenol or ibuprofen)**during school time, this written request completed by both the parent or guardian and licensed prescriber must be on file at the school before any administration of medicine will occur. In the absence of a licensed school nurse or health care tech, the student will self-administer the medication under the supervision of the school principal or his/her designee. If the student is not capable of self-administration of medication, the principal or other designated certified personnel shall administer the medication. All medication will be stored by the appropriate school personnel. NOTE: Every effort should be made to schedule the administration of medication at home outside the school day.

Part I To the Licensed Prescriber: _____ , _____should take
(name of student) (**date of birth**)
_____ of _____
(dosage) **(name of medication)**
at _____ for _____.
(time of day) **(period of time)**
Diagnosis of disease or injury _____
Desired benefits of medication _____
Medication side effects_____
Medication needs to be refrigerated Yes ____ No ____
Prescriber's signature _____
Prescriber's Name Printed _____ **Date**_____
Telephone _____ Fax Number _____

Part II Prescription medication must be in the original container labeled by the pharmacist or physician. The label must include: 1. Name of student 2. Name of medication 3. Amount and frequency of dosage 4. Physician's name 5. Date of prescription

Part III Non-prescription medication shall be in the original manufacturer's container with a label indicating the ingredients and the student's name affixed.

Part IV Parent agreement: I hereby authorize Olympia Community Unit School District and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. 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. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, 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 or attempts at administration of said medication.

_____ _____ _____
Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**