AUTHORIZATION FOR MEDICATION

The following section is to be completed by the PARENT/GUARDIAN: (please print)

Student's Name:_____ Birth Date:_____ Sex: M ☐ F ☐

School: _____ Grade:_____

Health Care Provider (HCP): Name:_____

Address:_____ Phone:_____ Fax:_____

⇒ I request that my child be assisted by authorized personnel in taking the medication prescribed below at school, or be permitted to self-medicate according to Heath Care Provider (HCP) instructions.

⇒ I understand that my signature on this form constitutes a waiver by me to the school district and authorized supervising personnel for liability for adverse reaction when medication is administered in the proper manner.

⇒ Changes to the time and/or dose of medication require written authorization from the HCP and Parent/guardian.

⇒ I understand that a medication dosage could be delayed or missed due to unexpected circumstances or changes in the student's schedule. If I am unable to accept this condition the district is not obligated to honor the request for administration of medication by school staff.

⇒ **Medication must be provided to the school in a properly labeled prescription bottle or the original over-the-counter container. Ask the pharmacist to supply a second prescription bottle for school use.**

⇒ I give permission for exchange of information between the school and HCP.

_____ _____ _____ _____

Parent/Guardian Signature | Date | Home Phone | Emergency Phone

☐ I request permission for my child to **self-carry medication for asthma or anaphylaxis during any school-sponsored activities occurring before/after school or overnight outdoor education programs**.

☐ I request permission for my child to **self-administer medication for asthma or anaphylaxis**. By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student.

_____

Parent/Guardian Signature

The following section is to be completed by the HEALTH CARE PROVIDER: (please print)

Diagnosis or reason for medication:_____

	Name of Medication	**Dose**	**Route**	**Time/Frequency**
#1	_____	_____	_____	_____
#2	_____	_____	_____	_____
#3	_____	_____	_____	_____

If medication is to be given AS NEEDED, describe instruction:_____

_____

Significant side effects:_____

Is child authorized to carry and self-medicate? Yes ☐ No ☐

If yes, for asthma and anaphylaxis medication, I have trained this student in the proper Administration and Frequency of use.

If ordered and the School Nurse is NOT AVAILABLE (e.g. field trip, after school activity etc.):

***Epinephrine Auto-injector WILL be given for ANY allergy symptoms or known ingestion.**

***Glucagon and Diastat WILL NOT be administered by other school staff, 911 will be called.**

Start Date: _____ Discontinue Date:_____ **or** end of school year ☐

_____ _____ _____

Health Care Provider Signature | Date | Phone

Return to: _____ _____ _____

School Nurse | Phone # | Fax #

School Address: _____