Authorization to Administer Medication

Date _____

To the Prescriber: The School District requires that of the following information be provided before it will administer medication or treatment to the student.

This will authorize school personnel to administer_____
(Medication)
To _____, _____.
(Student's Name) (Student's Address)
The prescribed dosage is _____to be given _____.
(Interval)
This is effective for _____ (time period).
Report the following side effects (i.e., severe adverse reactions) to my office immediately
_____
_____

_____ _____
(Physician's Signature) (Physician's Phone Number)

_____ _____
(Printed/Typed Name) (Date)

PARENT'S RESPONSIBILITIES IN REGARD TO THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL.

A. I am requesting permission for my child named above to: (Check all that apply)
_____ use or receive prescribed medication
_____ receive prescribed treatment
_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the authorized prescription.
B. I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)
C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)
D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

I have read and understand statement A through D above, and request that the medication indicated above be administered by school personnel at _____ to _____.
(School) (Student's Name)

_____ _____ _____
(Parent/Guardian Signature) (Date) (Parent/Guardian Home and Work Phone #)

Authorization For Staff

The following staff members are authorized to administer the above-prescribed medication/treatment:

_____
_____
_____
_____
_____

_____ _____

(Principal) (School Nurse)