Authorization/Parental Consent for Administering Medication

(Use a separate authorization form for each medication.)

Student's Last Name _____, First Name _____ MI_____

Grade_____ Date of Birth: _____/_____/_____

Allergies _____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in _____ School. I hereby acknowledge that I have read and understood the School Board Regulations relating to the taking of medications. I hereby release _____ School and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the below licensed prescriber.

_____ _____ _____

Parent/Guardian Signature Daytime Phone Date

MEDICATION AUTHORIZATION
(For Use by Licensed Prescriber <u>ONLY</u>)

Relevant Diagnosis _____ Medication _____

Dates medication must be administered at school: _____ Short Term (List dates to be given _____)

_____ Every day at school _____ Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

A. Serious reaction can occur if the medication is not given as prescribed. _____YES _____NO

If yes, describe:

B. Serious reactions/adverse side effects from the medication may occur: _____YES _____NO

If yes, describe:

Action/Treatment for reactions. _____

Special Handling Instructions _____Refrigeration _____ Keep out of sunlight ____Other _____

Asthma/Diabetic <u>ONLY</u>

This student is both capable and responsible for self-administering this medication:

_____ NO _____ YES-supervised _____Yes-unsupervised

This student may carry this medication: _____NO _____YES

Licensed Prescriber's Name: _____

Telephone Number: _____ Emergency Number: _____

Licensed Prescriber's Signature: _____ Date: _____