Authorization for Medications to be Taken During School Hours

The following section is to be ***PRINTED*** by the Parent/Guardian:

SCHOOL: ____________________

CHILD'S NAME: ____________ (Last) ____________ (First) ____ (MI) ____ (Sex) __/__/__ Date of Birth

____________ (Physician's Name) ____________ (Address) ____________ (Phone #)

The following is to be completed by the Physician:

DIAGNOSIS FOR WHICH MEDICATION IS GIVEN: ____________________

Name of Medicine:	
Form:	
Dose:	
If medicine is to be given *DAILY*, at what time?	
If medicine is to be given "WHEN NEEDED", describe indications below:	
If You See This:	**Do This:**
How soon can it be repeated?	
Is child authorized to medicate herself/himself?	
List significant side effects:	
Length of time this treatment is recommended:	
List any limitations:	

☐ I authorize the School Nurse to administer the above medication.

☐ I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. She/he has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

____________________ (Physician's Signature) ____________ (Date)

To be completed by the Parent/Guardian:

☐ I authorize the School Nurse to administer the above medication.

☐ I hereby request that my child be allowed to carry/keep and self-administer the above medication as indicated by the physician. I verify that my child knows how to administer the medication. I understand it is my responsibility to provide the medication.

I understand that the district and its employees or agents shall incur no liability as a result of injury arising from the self-administration of medication by the pupil or as administered by the school nurse. I indemnify and hold harmless the district and its employees or agents against any claims arising out of self-administration or lack of medication by the pupil.

____________________ (Parent/Guardian's Signature) ____________ (Date)