PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the medication described below, in the original container, be administered to my child during the school day. I understand that a licensed school nurse or trained unlicensed school personnel will be performing this service utilizing the order provided by my child's physician or licensed health care provider. I acknowledge that the School District and its employees and agents shall incur no liability as a result of administration of this medication to my child and agree to indemnify and hold harmless the School District and its employees and agents from legal fees, costs, and any potential damages arising from medication administration. I give the school nurse permission to contact the physician, health care provider and/or pharmacist with any questions concerning the medication. I understand and agree that it is my responsibility to resupply the medication when the initial supply has been depleted.

Student Name:_________________________DOB:_____________Grade:___________________
School:____
Medication(s):____
Dose:_______Strength:________________Time(s) to be Administered:___________________

Parent/Guardian Signature:________________________________Date:___________________
Print Name:__________________________Phone Number:______________________________

INITIAL MEDICATION SUPPLY:

Name of Medicine:__________________________# of pills/tablets/capsules/ml:____________
Nurse Signature:_____________________________Date:_______________________________

PHYSICIAN'S ORDER FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

(To be Completed by Physician)

*Student's Name:*_______________________*DOB:*___________________*Grade:*____________
*Name of Drug:*_________________________*Dosage:*_________________________________
*Diagnosis/Reason for Medication:*____
*Possible Side Effects:*____
*Time(s) to be Administered:*_________________________*Duration of Use:*________________
*Physician's Signature:*____*Date:*____________

Please Print or Stamp: *Physician's Name*
Address
Phone Number

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