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

ADOPTED: June 18, 2024
AMENDED: