Brimfield Public Schools/District 309
Medication Authorization Form

Student Name: _____ **Date of Birth**_____ **Teacher/Grade:** _____

Parent/ Guarding Name:_____ **Phone:** _____

Physician: _____ **Physician Phone:** _____

As the parent/guardian, I understand that it is the policy of the district that as a regular and normal practice, medications should no t be administered to a student at school or when such student is involved in school activities. However, in order to provide for the crucial health and well-being of students, under some circumstances, medication may be administered during school hours by a certified school nurse, administrative personnel, administrative designee, or self-administered by the student. I further release Brimfield Public Schools, its Board of Education, and individual members thereof, and its employees shall be indemnified and held harmless from any and all claims arising out of administration of said medications.

I request that my child be assisted and/or supervised while taking the medication(s) described below at school by authorized persons or be permitted to medicate himself/herself as also authorized by me and my physician (see below). I further consent to the sharing of relevant medical information between the school and the physician's office.

_____

Parent/Guardian Signature Date

The following section must be completed by the PHYSICIAN. All items must be completed before the school will allow the student to take any medications.

Medication: _____

Purpose of Medication/Diagnosis: _____

Dose: _____

Time range medication is to be taken: _____

If medication is "as needed", describe indication: _____

Is child authorized to medicate himself/herself: _____

Must this medication be given during the school day in order to allow the child to attend school or to attend to the student's medical condition that may arise at school? Yes NO

_____

Physician's Signature Date

To be completed by the building School Nurse: Approved_____ Not Approved_____

Nurse Signature: _____ Date:_____

Date medication sent home: _____ Date medication destroyed: _____

School Nurse:_____ Witness:_____