MEDICATION AUTHORIZATION

PARENT/GUARDIAN FORM

Please print:

STUDENT: _____ BIRTH DATE: _____ GRADE: _____

MEDICATION NAME: _____

DOSE: _____ METHOD OF ADMINISTRATION: _____

TIME/FREQUENCY: _____ START DATE: _____ END DATE: _____

REASON FOR MEDICATION: _____

IF "AS NEEDED," CONDITIONS UNDER WHICH PRESCRIBED MEDICATION SHOULD BE GIVEN:

_____

PRECAUTIONS, POSSIBLE UNDESIRABLE REACTIONS, AND/OR INTERVENTIONS: _____

_____

IS THIS MEDICINE PRESCRIBED BY A PHYSICIAN (CHECK ONE)? _____ YES* _____ NO

(*If yes, have physician complete Physician Form available from Nurse Ball at the school, or from the link on the District's Health and Wellness page, or at http://www.cheyennesd.net/pdfs/dr.pdf)

_____ _____ _____

Physician's Name Phone # Fax #

_____

Address

_____

City, State, ZIP

- I give my permission to school personnel to give this medication to my child according to the preceding directions and to contact my child's physician if necessary.
- If this medication is injectable, school employees who have been trained in techniques of administering subcutaneous or intramuscular injections have my permission to administer it.
- **Medications must be brought in to school by a responsible adult in the original container.**
- I agree to hold the school district and personnel harmless in any claims arising from the administration of this medication at school.
- I agree to notify the school in writing when any change in the preceding orders is necessary.

_____ _____

Signature of Parent/Guardian Date

***** SCHOOL USE ONLY *****

To be completed by school principal

I designate the following employees as authorized to administer this medication:

1st _____

2nd _____

3rd _____

_____ _____

Signature of Principal Date