Student Medical Authorization Form – Administration of Medication

This form is required when a student needs to take prescription and/or non-prescription medication at school.

_____	____/____/____	_____	_____
Student's Name	Birth Date	School	Date

School medications and health care services are administered following these guidelines:

- Physician/prescriber signed and dated authorization to administer the medication is required.
- Parent/guardian signed and dated authorization to administer the medication is required.
- The medication must be in the original labeled container as dispensed or the manufacturer's labeled container.
- The medication label must contain the student's name, name of the medication and directions for use and date.
- Annual renewal of authorization and immediate notification of changes is required.

Physician Authorization:

_____	_____	_____
Medication/ Treatment	Dosage	Time to be Administered

_____	_____
Intended Effect of Medication/Treatment	Side Effects (if any)

_____
Other Medication(s) the Student is Taking

May the student self-administer the medication under the supervision of a nurse or school designee?
_____ Yes _____ No

Administration Instructions:

_____

_____

Date to Discontinue, Reevaluate or Follow Up:

_____

_____	_____
Physician's Signature	Date Signed

_____	_____
Physician's Emergency Phone Number	Physician's Address

Parent Authorization:

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Taft School District 90 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child or to allow my child to self-administer while under the supervision of an employee or agent of the

(over)

School District, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against the School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School Districts, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

_____ _____

Parent's Signature Date Signed

_____ _____

Parent's Phone Number Parent's Emergency Phone Number

Additional Information:

_____

_____