

Mason Elementary School | - SAU 89

MEDICATION ADMINISTRATION AUTHORIZATION FORM

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

Teacher/Advisor \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication \_\_\_\_\_

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Diagnosis/Condition \_\_\_\_\_

Dose, Route other Administration Instructions \_\_\_\_\_

Frequency & Time(s) to be given at school \_\_\_\_\_

Dates to be given: \_\_\_\_\_ - \_\_\_\_\_ school year, or \_\_\_\_\_

Optional:

If an AM dose is given at home and is omitted, a dose of \_\_\_\_\_mg may be given at school after omission is verified by a parent/guardian. School dose may then be given \_\_\_\_\_ hours later.

Special Side Effects, Adverse Reactions or Contraindications \_\_\_\_\_

Additional information \_\_\_\_\_

Licensed Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Licensed Prescriber Telephone Number \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION

PLEASE LIST ALL MEDICATION THE CHILD IS TAKING AT HOME (Prescription and over the counter medications) if not a violation of confidentiality

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

I hereby authorize the designated staff person or school nurse to administer the above medication as directed. In consideration for this service, I further agree that I will not hold liable, and will otherwise save harmless, the District and/or any department or employee thereof for death or injury resulting from administration or assistance in the administration of the medication described above. I understand that (a) not more than one month of prescribed medicine may be stored in school, (b) medication will be delivered directly to the School Nurse, Principal or designated staff member by the parent or guardian, and (c) the medication will be delivered in an original pharmacy container properly labeled with the student's name, the physician's name, the date of original prescription, name and strength of medication and directions for use.

Printed Name of parent/guardian \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

I give my permission for release/exchange of pertinent information by telephone, mail or electronic exchange including fax or e-mail between the school nurse and the physician's office regarding the above medication.

I give my permission for other school personnel to be notified of the medication and any adverse effects.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_