

AUTHORIZATION FOR ALL MEDICATIONS TAKEN DURING SCHOOL HOURS, SCHOOL ACTIVITIES AND FIELD TRIPS

This form must be completed at least annually and more frequently if the prescription changes in any way or as designated in the Individual Education Program (IEP) or in the Rehabilitation Act, Section 504 Plan.

PARENT OR LEGAL GUARDIAN

1. Parent or Legal Guardian Section

Note: All medications must be prescribed, **including over-the-counter medications**. Medications must be in the original container and the label must include the child's name, name of the medication, dosage, method of administration, time schedule and name of physician or other licensed health care provider (LHCP). Please refer to Legal References Governing the Administration of Medication in Schools on the reverse side of this form.

I request that designated unlicensed, trained school staff or licensed nurse assist my child in taking this prescribed medication(s) (including prescribed over-the-counter medication). I understand that my child may not be assisted with medication at school until all requirements are met. I hereby give consent for a school nurse to communicate with my child's prescriber and/or the pharmacist and to counsel school personnel as needed with regard to my child's health. I agree to comply with local educational agency policies and regulations related to administering medication at school.

Name of Child _____ Birth Date _____ Student Identification Number _____

Name of School _____ Grade _____ Teacher/Room Number _____

List all medications routinely taken outside of school hours: _____
I will immediately notify the school if there are any changes in medications my child is taking at school.

☐ If ordered by a LHCP, I give consent for my child to self-administer emergency medication at school. I agree to and do hereby release and hold the local educational agency and its governing board, officers, agents, employees and volunteers harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of self-administration of the medication(s).

Signature of Parent or Legal Guardian _____ Date _____ Primary Telephone _____ Alternate Telephone _____

2. Licensed Health Care Provider Section

The child named above is under my care for these diagnoses: _____
It is necessary for the child to receive the following prescribed medication(s) during school hours.

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____

Storage and handling ☐ Routine handling, medication in locked storage and administered by authorized school personnel
☐ On-site 72 hour disaster supply only
☐ It is *Medical Necessity* for child to carry prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Name of Medication _____ Dosage (be specific, i.e. milligrams, etc.) _____
Time of day to be given _____ Frequency and Indication if "as needed" _____
Method of administration _____ Duration _____
Precautions or side effects _____

Storage and handling ☐ Routine handling, medication in locked storage and administered by authorized school personnel
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Storage and handling ☐ Routine handling, medication in locked storage and administered by authorized school personnel
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☐ It is *Medical Necessity* for child to carry prescription for anaphylaxis, asthma, or diabetes, and indicate:
☐ Designated school personnel to administer
☐ Child trained to self-administer

Signature of LHCP or Supervising Physician _____ Date _____

Name of LHCP (please print) _____ License Number _____ Office telephone _____

Stamp LHCP name/address below:

Licensed Health Care Provider