AUTHORIZATION TO ADMINISTER MEDICATION
(For Non-Asthma Medications)

Many children are able to attend school because of the effectiveness of medications in the treatment of many chronic disabilities and long and short-term illnesses. If possible, all medications should be given at home. However, if your child's physician decides it is necessary for your child to receive a medication during the school day, the approval and specific directions must be provided to the school. It is recommended that the first dose of medication be administered at home. Note: A separate form is required for each medication and a new form must be completed for any change in dose, time or method of administration. The 'Authorization to Administer Medication' form is valid for the current school year only.

For medication to be safely administered at school every item on this form must be completed.

Student's Name ____ DOB __________________

School Year: _________________ Teacher ___________________________________ Grade _____________
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PHYSICIAN'S STATEMENT

1. I have examined this student for (diagnosis) _________________ on (date) ________ and have determined that he/she requires medication during school hours.
2. Name of medication ___________________________________ Dose ________________
   Route_____________ Time of administration ____________Duration _______________
3. In the event the morning dose is not given at home, the following may be administered on a PRN basis: ____
4. Side effects that may be experienced ____
5. Please contact me if the following signs or symptoms appear
   ____

Physician's Name (print)	Physician's Signature
Date	Phone Number

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PARENT/GUARDIAN STATEMENT

1. I/We the undersigned parent(s)/guardian(s) of the above named student hereby request the school nurse (or designee) to administer and/or supervise self administration of the above mediation according to the physician's instructions.
2. I/We agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement medication as necessary and to notify the school nurse immediately if the physician or medication prescription is changed.
3. I/We authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provided listed on this form.

Parent's/Guardian's Name (print)	Parent's/Guardian's Signature

Date	Home Phone Number	Work Phone Number	Cell Phone Number

THE DISTRICT (INCLUDING ITS EMPLYEES AND AGENTS) SHALL NOT INCUR ANY LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE STUDENT'S TRANSPORT OR SELF-ADMINISTRATION OF MEDICATION, AND THE PARENT/GUARDIAN SHALL INDEMNIFY AND HOLD HARMLESS THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) AGAINST ANY CLAIMS ARISING OUT OF THE TRANSPORT AND SELF-ADMINSTRATION OF MEDICAION.